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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

Hearing held  
8th floor  
180 Dundas Street West  
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

P.S.A. Lamek, Q.C.

E.A. Cronk

Thomas Millar

Commissioner

Counsel

Associate Counsel

Administrator

Transcript of evidence  
for

December 21, 1983

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BROWNE  
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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN  
AND RELATED MATTERS.

Hearing held on the 8th Floor,  
180 Dundas Street West, Toronto,  
Ontario, on Wednesday, the 21st  
day of December, 1983.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

APPEARANCES:

E. CRONK	Commission Counsel
D. HUNT ) L. CECCETTO)	Counsel for the Attorney General and Solicitor General of Ontario (Crown Attorneys and Coroner's Office)
M. THOMSON) R. BATTY )	Counsel for The Hospital for Sick Children
D. YOUNG	Counsel for The Metropolitan Toronto Police
K. CHOWN	Counsel for numerous Doctors at The Hospital for Sick Children
F. KITFEE	Counsel for the Registered Nurses' Association of Ontario and 35 Registered Nurses at The Hospital for Sick Children









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/ DM/ak

---Upon commencing at 9:30 a.m.

3

CAROL BROWNE, Resumed

4

THE COMMISSIONER: Yes, Mr. Brown.

5

MS. CRONK: Before we begin I notice

6

Ms. Browne's counsel is not here. I don't know

7

whether Ms. Kately has arrived yet, I think under

8

the circumstances it would be best to wait. Perhaps

9

I will just check in the hall.

10

THE WITNESS: Her briefcase is here  
but I have not seen her.

11

THE COMMISSIONER: Is there any

12

sign?

13

MS. CRONK: No, I am sorry, sir.

14

THE COMMISSIONER: Well, I don't

15

know of any rule respecting the matter. If you

16

have any concerns at any time, Mrs. Browne, we will

17

call it off, but I think the current counsel is

18

reasonably friendly, I don't think you need to be

19

THE WITNESS: With respect for timing.

20

THE COMMISSIONER: That is what I

21

had in mind, because we are going to be in trouble

22

in meeting the ---

23

CROSS-EXAMINATION BY MR. BROWN: (Continued)

24

Q. Ms. Browne, at the end of my

25





1  
2 cross-examination yesterday I was asking you a few  
3 questions about intravenous medication. There had  
4 been references in the medical records of some of  
5 the children that we have looked at, to an IV going  
6 interstitial, could you please explain to me what  
7 that means?

8 A. It means that the needle - we  
9 don't have it up yet this morning.

10 THE COMMISSIONER: Here we are.

11 THE WITNESS: It is displaced from  
12 the vein and so instead of the fluid flowing into  
13 the vein it does flow into the tissue and the tissue  
14 cells.

15 MR. BROWN: Q. If the needle goes  
16 interstitial would that be observable by a nurse or  
17 a doctor?

18 A. Yes.

19 Q. And what would trigger, or  
20 draw their attention to that fact?

21 A. Either redness or swelling.  
22 If the patient is old enough they would complain that  
23 it is uncomfortable.

24 Q. If they notice that an IV has  
25 gone interstitial what procedures are they required  
to follow?







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A. You would check to be sure that it is interstitial, and you can do that by dropping the bag below the level of the patient and if it is in the vein then will blood return back through the needle. In that case if it is out of the vein then you would remove the needle.

Q. And is a registered nurse caring for the child authorized to remove the needle if she observes that the IV is interstitial?

A. Yes.

Q. Would a registered nursing assistant be authorized to remove the needle?

A. No, she would speak to the registered nurse.

Q. Once the needle had been removed would any registered nurse be authorized to reinsert the IV needle and recommence the IV running?


A. No.

Q. And who would be authorized to do that?

A. It would be a designated nurse, be that a nurse with the IV team, or a doctor.

Q. And they would then come and reinsert the needle into the vein?

A. Yes.



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Q. So if a nurse who was not qualified or certified to reinsert the needle observed that an IV had gone interstitial her sole authorized function would be to remove the needle, is that correct?

7

A. That is correct.

8

9

10

Q. And from the time that she removed the needle until the time that an authorized person arrived and inserted the needle, the IV would not be running?

11

A. That is correct.

12

13

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15

16

Q. So that when we see a reference to the IV going interstitial would it be safe to assume that that would record an observation by a nurse or a nursing assistant that the IV had gone interstitial and that the needle had been removed?

17

18

19

20

A. It might be reported that it had gone interstitial and the IV might have been stopped by the control device. It would not necessarily mean that needle had been removed unless it was recorded as such.

21

22

Q. Would it mean that at the minimum fluid would stop running into the child?

23

A. Yes.

24

25

Q. One final matter if I can





1  
2  
3 return to something that was dealt with briefly  
4 yesterday. Right at the beginning of your examina-  
5 tion by your counsel Ms. Kitley, she questioned you  
6 about the approaches made to you by Nurses Trayner  
7 and Nelles during the summer of 1980, and asked you  
8 why they would have approached you, and if I recall  
9 your answer you stated that it was logical that  
10 Nurse Trayner would approach you since she was the  
11 team leader and it was logical that Nurse Nelles  
12 would approach you since in many cases she had care  
13 of very sick infants, is that a correct summary of  
14 your testimony yesterday.

15 Q. Was it your understanding  
16 that Nurse Nelles was assigned to care for children  
17 who were very sick?

18 A. Often, yes.

19 Q. And would she be assigned more  
20 than another nurse on her team to care for such  
21 children?

22 A. Yes, because of her experience.

23 Q. Because of her experience she  
24 had some expertise in treating sick infants?

25 A. Yes.

Q. Was she one of the more senior  
nurses on that team?







1

2

A. Yes.

3

4

Q. Indeed she was really junior  
only to the team leader, Phyllis Trayner?

5

A. That is correct.

6

7

Q. And I take it that she was  
assigned to care for these children because of her  
expertise and the fact that she was a competent nurse?

8

9

A. Yes.

10

Q. And in your observation of her  
is it your opinion that she was a competent nurse?

11

A. Yes.

12

13

Q. And that she had a concern  
for the welfare of her children?

14

A. Yes.

15

16

Q. And indeed she had a concern  
for the welfare of the families of the children?

17

A. Yes.

18

19

Q. Nelles and Trayner approached  
you during July and August, and indeed they brought  
to your attention the deaths of the infants Dawson  
and Hoos, did they not?

20

21

A. Yes.

22

Q. I take it that they approached  
you?

23

24

A. Yes.

25







1

2

Q. You did not approach them?

3

A. No.

4

Q. They took the initiative?

5

A. Yes.

6

Q. They indicated to you that they had some concern about the care which they had given to these children?

7

8

A. Yes.

9

10

Q. They were seeking your advice on improving their own qualifications and competence as nurses?

11

12

A. Yes.

13

14

Q. And you were a person who could of course give them further assistance and pointers in improving their care?

15

16

A. Yes.

17

Q. Not only that they were enquiring as to why these children died?

18

A. Yes.

19

20

Q. And as a result of their enquiry you approached some of the cardiologists, in particular Drs. Freedom and Rowe?

21

22

A. Yes.

23

Q. And your conversations with them centred in part upon why these children died?

24

25





1

2

A. Yes.

3

Q. So there was a concern then

4

initiated by Nurses Trayner and Nelles as to the  
5 cause of death of these children?

6

A. Yes.

7

Q. And they wanted a further

8

explanation of why these children died?

9

A. Yes.

10

Q. They were concerned that the

children had died?

11

A. Yes.

12

Q. And they called in to question

13

their own competence?

14

A. Yes.

15

Q. And they sought a solution

16 to the problem?

16

A. Yes.

17

Q. And as a result of their

18

contact with you and your contact with the doctors

19

further investigation of these particular children

20

was done, in the sense that mortality rounds were

21

especially called at which the deaths of some of

22

these children were reviewed?

23

A. Yes.

24

Q. And the deaths of these children

25







1

2

were reviewed by the staff cardiologists?

3

A. Yes.

4

5

6

Q. As a result then of the initiative of Trayner and Nelles the cardiologists gave a second look at these children?

7

A. Yes.

8

9

Q. And they went into their clinical history in some depth, did they not?

10

A. Yes.

11

12

Q. And indeed they looked at both the clinical picture and the pathological picture, did they not?

13

A. Yes.

14

15

16

17

18

Q. Would it be your expectation that if a nurse had some concern about the quality of care she had given to a child, or some concern about why a child died, that that nurse would in fact do precisely what Nurses Trayner and Nelles did, that is seek the assistance of their supervisors?

19

A. Yes.

20

21

MR. BROWN: Thank you, those are my questions.

22

23

24

25

THE COMMISSIONER: Thank you,  
Mr. Brown. Miss Forster.





1  
2  
3 CROSS-EXAMINATION BY MS. FORSTER:

4 Q. Good morning, Ms. Browne,  
5 my name is Elizabeth Forster and I act on behalf of  
6 Phyllis Trayner.

7 Ms. Browne, I believe you indicated  
8 in your evidence that it was your perception that  
9 during this nine month period there were younger  
10 and sicker babies on the Cardiology Ward; is that  
11 correct?

12 A. Yes.

13 Q. We have also heard evidence  
14 that during this nine month period the occupancy  
15 rate in the ICU was particularly high, is that  
16 something of which you were aware?

17 A. Yes.

18 Q. And was it your perception  
19 that children were leaving the ICU earlier than they  
20 had in previous periods?

21 A. In some instances.

22 Q. And was it also your perception  
23 that children were being transferred to the ICU as  
24 quickly as they might have in the past?

25 A. In some instances there was  
a space problem, yes.

THE COMMISSIONER: I think the





1  
2  
3 question was, was it a greater problem than at other  
4 times?

5 THE WITNESS: Yes.

6 MS. FORSTER: Q. Were concerns  
7 about the situation ever expressed to you by any  
8 of the parents of children?

9 A. Some of the parents whose  
10 children had left Intensive Care earlier than  
11 they might have expressed concern.

12 Q. Can you recall the nature of  
13 the concerns that were expressed to you by the  
14 parents?

15 A. They were not unusual concerns.  
16 Most parents after they have spent a period of time  
17 in Intensive Care where there is a nurse constantly  
18 available really feel a loss of that security, if  
19 you will, and confidence that there is someone there  
20 monitoring the child all the time, so that was not  
21 an unusual concern; but particularly where a child  
22 did leave Intensive Care sooner that was more of  
23 a concern for their family.

24 Q. During this nine month period  
25 did the concerns expressed by parents either increase  
in frequency, or differ in the nature of the concern?

A. Increased in regard to the







1  
2  
3 number of children who were leaving Intensive Care  
4 earlier.

5 Q. Was concern about this  
6 situation ever expressed to you by any of the  
7 nurses on 4A or 4B?

8 A. I don't know that it was  
9 expressed in those terms, but a feeling that indeed  
10 the nursing load was heavier.

11 Q. And was the expression to you  
12 of the fact that the nursing load was heavy expressed  
13 in the context that they were seeing children from  
14 ICU faster, or just a general concern about increased  
15 load?

16 A. In part it was related to  
17 the children coming from Intensive Care and needing  
18 closer supervision.

19 Q. I was a little unclear about  
20 your evidence yesterday when you were discussing  
21 the approaches made to you by Nurses Trayner and  
22 Nelles after the death of some of the babies. As  
23 I understand it the first time you were approached  
24 by these two nurses was after the death of Amber  
25 Dawson.

A. Yes, that is correct.

Q. At which time Phyllis Trayner





1  
2  
3 and Susan Nelles advised you of the fact that Dawson's  
4 mother would be coming in that morning?

5 A. Yes.

6 Q. And as I understand it the  
7 second time they approached you was after the death  
8 of Lillian Hoos when you were again approached by  
9 Susan Nelles and Phyllis Trayner, and this eventually  
10 led to the coffee meeting in the cafeteria?

11 A. Yes.

12 Q. Can you tell me what was  
13 said during that meeting?

14 A. Not specifically.

15 Q. I believe you have told us  
16 that the general discussion was around concerns  
17 about the quality of care and the number of deaths,  
18 can you remember anything else that took place  
19 during that meeting?

20 A. It was the quality of care  
21 and were indeed they picking up soon enough in  
22 terms of nursing observation and communicating that,  
23 so were actions being taken quickly enough for these  
24 babies.

25 Q. How did you respond to the  
concerns expressed to you during the meeting, not in  
subsequent actions, but during that meeting do you







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2

recall how you responded to these concerns?

3

A. It would be looking at what

4

their concerns had been around the child becoming

5

sicker and what actions had they taken, and

6

re-enforcing how they had acted responsibly.

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Q. So it was your opinion that they had acted appropriately under the circumstances?

A. Yes.

Q. And you expressed that to them?

A. Yes.

Q. I believe you said the third time that Susan Nelles and Phyllis Trayner approached you was some time in about the middle of August after there had been a further series of deaths?

A. Yes.

Q. At that time Bertha Bell also approached you?

A. Yes.

Q. Do you recall what was said during that discussion?

A. It was not unlike what had been said earlier, but indeed they were feeling the load heavier again.

Q. When you say they were feeling the load heavier, do you mean their patient load?

A. Yes.

Q. And other than the patient load, were any other concerns expressed to you?

A. Concerns were raised around medical back-up and the communication between nursing





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and medicine.

Q. What was the concern about  
medical back-up; what do you mean by that?

A. Availability of medical staff  
and --

Q. How was that a concern?

A. Concerns about their availability  
at nighttime, who was and who was not in the hospital,  
and concerns about the support that they felt either  
in attitude or in behaviours.

Q. All right. I am having a little  
difficulty understanding what you mean by concerns  
about who was and who was not in the hospital. Can  
you be a bit more specific about what the particular  
concern was?

A. Well, it had to do with some of  
the cardiology staff who were not as competent in terms  
of English language, and there had been a back-up  
cardiology staff assigned but that back-up person was  
not in the hospital all the time.

Q. How did the nurses feel that this  
was a problem? There is an obvious problem with  
communication in the English language, but the fact  
that they were not in the hospital all the time, how  
did they see that as a problem?







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A. That they were not as available at critical times.

Q. Did this concern centre around the person who was to be on call for the cardiology ward?

A. Yes.

Q. This would be a resident as opposed to the staff cardiologist about whom they were expressing concerns?

A. It would be a cardiology fellow, and might I add that the residents changed the beginning of July, so for the first couple of months into a new rotation you have a number of residents who may or may not have pediatric experience and probably do not have cardiology experience.

Q. Was that concern also expressed to you by these three nurses?

A. Yes.

Q. Do you recall any other specific concerns they had that they expressed to you during that conversation?

A. No.

Q. Again, do you recall how you responded to their concerns during that discussion?

A. Again, looking at problem solving,





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what had they done, specific concerns and the concerns around communication and how could we indeed approach solving that problem.

Q. Do you recall specifically what you said?

A. No.

Q. Do you recall making any suggestions as to how these problems could be solved?

A. I remember some suggestions in terms of increasing communication with medical staff and conveying their concerns to head nurses as well as to cardiologists.

Q. During that discussion, did you express any concerns about the way these three nurses or any other nurses had handled the situation?

A. Not that I recall.

Q. You also indicated yesterday that during the fall of 1980 some of the nurses had raised the possibility of meeting with a psychiatrist on a regular basis to deal with the stress they were feeling on the ward. Was this something that was unprecedented in the hospital? Did it strike you as an unusual request?

A. Not at all, no.

Q. Was it something that had been







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done in the past at the hospital?

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A. It was done on a regular basis in the Intensive Care Unit and the staff there found that very helpful.

6

7

Q. When you say on a regular basis, how frequently did the staff in ICU meet with a psychiatrist?

8

9

10

11

A. I believe it was once a week and with the 12 hour shift in rotation, that would mean that staff would be available once or twice a month to meet with the psychiatrist.

12

13

14

Q. When you say it was the staff that met with the psychiatrist, was this simply nurses or did it include other members of the hospital staff?

15

16

A. It included the medical staff.

17

18

Q. Do you know what the purpose of these meetings was?

19

20

21

A. To help them deal with stress in an acute area.

Q. When the nurses on 4A/4B were raising the possibility of having a psychiatrist, was it based on the fact that they knew that there was such a procedure in ICU?

22

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A. Yes.

Q. Was one of the reasons for having





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a psychiatrist in ICU the fact that they were dealing probably with more deaths in their situation than, say, on some of the other wards in the hospital?

A. I think in part it was deaths; the other part being that it is a critical area so the children were really sick and the families were really stressed.

Q. Finally, I wanted to ask you a few questions about medication. You indicated that for the most part nurses could not administer medication in the IV line; is that correct?

A. Below the buretrol, yes.

Q. All right, and that must be done by a doctor?

A. Yes.

Q. If a doctor is administering a medication, who in practice normally draws up that medication?

A. The doctor generally.

Q. Other than the emergency situations that you have told us about, I think you indicated an emergency nurse might draw up medication for doctors, other than the emergency situations, are you aware of any other practice on the ward whereby nurses would draw up medication for doctors to administer IVs?





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A. No.

3

Q. You also indicated that RNs were normally the ones who administered oral digoxin because they had to take the apical rate prior to administration; is that correct?

6

A. That is correct.

7

Q. Was this always the case?

8

A. As far as I knew, yes.

9

Q. The reason I ask is if we turn to the 4B communication book, at page 64 --

10

11

THE COMMISSIONER: That is Exhibit number?

12

13

MS. FORSTER: I am sorry, I do not have the number on it.

14

MS. CRONK: 300.

15

16

MS. FORSTER: 300, sir. It is the second tab.

17

18

19

Q. Page 64, and this is under the date of November 18th, we were discussing it yesterday. It deals with the medication errors respecting digoxin.

20

A. Yes.

21

22

23

24

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Q. There is a reference in there to three occasions on which a relief nurse and one occasion on which a student gave digoxin at 0900 when it should not have been administered. I take it, or







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perhaps you can tell me, did all of those errors involve  
oral digoxin?

3

4

A. Yes.

5

Q. In your experience, were student  
nurses giving oral digoxin to patients?

6

7

A. When supervised.

8

Q. I take it student nurses are not  
registered nurses?

9

A. That is correct.

10

Q. Well then, there is an exception  
to the general rule that only RNs give oral digoxin?

11

12

A. Yes.

13

Q. Was it acceptable for students,  
as a matter of routine, to give oral digoxin if they  
were supervised?

14

15

A. I think that would be better  
directed to the head nurse.

16

17

Q. Do you know if the relief nurses  
and the student who made the medication errors in this  
instance also drew up the medication?

18

19

20

A. I assume so.

21

Q. Again, with respect to the  
student, that would be contrary to the hospital  
protocol which requires that RNs draw up medication?

22

23

A. Again, she would have been

24

25





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supervised by a RN.

3

Q. But it would still be contrary  
to the protocol which requires a RN to draw up  
medication?

5

A. Yes.

6

7

Q. Again, do you know whether, as  
a matter of practice, student nurses often prepared  
medications under supervision?

8

9

A. Generally they did.

10

Q. They did?

11

A. Yes.

12

Q. Are medications normally all  
drawn up at the beginning of a shift?

13

A. No.

14

Q. They are drawn up when needed?

15

A. Just prior to administering

16

the medication to the patient.

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Q. You also indicated to Miss Cronk last week that you had thought that digoxin was on the crash carts in 4A/4B?

A. Yes.

Q. Had you ever seen digoxin on the crash carts on the ward?

A. In other wards, yes; I can't say specifically for 4A/B.

Q. You just can't remember one way or the other?

A. No.

Q. All right. What made you think that digoxin would be on the crash carts on that ward?

A. Because I have seen it on crash carts.

Q. Finally, you also indicated I thought that at that time during the nine month period under review that epinephrine on the crash carts was in the form of pre-mixed syringes?

A. I indicated to - can I go back to that list.

Q. Yes.

A. Yes, I had.

Q. Do you have before you a







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2

copy of Exhibit 294?

3

A. Can you give me a formal heading for it?

4

5

Q. Yes, it's got the covering memorandum from Douglas Snedden dated April 13th as the front page.

6

7

A. Yes, I do.

8

9

Q. Can I ask you to turn to the second page of the manual, it is the third page of the document?

10

11

A. Yes.

12

Q. And that page starts with step 3.

13

14

A. Yes.

15

Q. And if you go down to step 7 and look at the right-hand column it says:

16

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"The sodium bicarbonate 8.42 per cent and epinephrine 1 to 10,000 come in pre-mixed syringes that require only the screwing in of the barrel containing the drug. Further supply of these and other drugs are in the top drawer of the crash cart. If epinephrine 1 to 20,000 is required use a 20 ml. syringe, draw





1

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"up 19 ml. sterile water and 1 ml.

3

epinephrine 1 to 1000."

4

A. Yes.

5

Q. I take it from that, Miss

6

Browne, that if epinephrine 1 to 20,000 was required

7

it would require mixed in by a nurse or somebody

8

at the resuscitation, is that correct?

3

A. That is correct.

9

MS. FORSTER: Thank you, those are

10

all my questions.

11

THE COMMISSIONER: Thank you.

12

Mr. Hunt?

13

CROSS-EXAMINATION BY MR. HUNT:

14

Q. Ms. Browne, my name is Hunt

15

and we represent the Attorney General and the

16

You mentioned yesterday that you

17

had some written information from the Police. I

18

take it you are referring to a statement?

19

A. It was the statement in

20

question yesterday; it is not a signed statement.

21

Q. All right. When was the last

22

A. Last week.

23

Q. And was that in connection with

24

25





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preparing for your evidence here?

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A. Yes.

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Q. And you read it with a view

5

as to refreshing your memory as to what you told  
them at that time?

6

A. Pardon?

7

Q. Did you read it with a view

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to refreshing your memory with respect to what you  
told the Police at that time?

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10

A. Yes.

11

Q. Did you find that that

12

assisted you?

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A. I didn't find it a very good  
record of what had transpired.

14

Q. My question - I want you to

15

get this straight at the outset. I want you to

16

listen carefully to my question, all right. Did

17

you find it assisted you?

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A. Yes.

19

Q. All right. Do you have that

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statement here?

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A. It is in my brief case.

22

Q. I wonder if I could see it,

please.

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MS. KITELY: Mr. Commissioner, I

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25







1  
2 guess we now have to deal with the issue of this  
3 statement.

4 THE COMMISSIONER: We now have to  
5 deal with the problem, yes.

6 MR. HUNT: It seems it is on a  
7 different plane at this point. If the witness  
8 has refreshed her memory for the purpose of giving  
9 evidence we are no longer just dealing with the  
10 relevance in the abstract we are now dealing with  
11 something that by virtue of the fact that she has  
12 dealt with it in order to prepare herself to  
13 testify and my submission becomes something in the  
14 cross-examination ---

15 THE COMMISSIONER: Then it applies  
16 of course to every statement; if that is so it  
17 applies to every statement because every witness  
18 has been given any statements that the Police have  
19 taken from them.

20 MR. HUNT: Well, it may depend on  
21 whether they have used it to refresh their memory  
22 or not.

23 THE COMMISSIONER: Well, it would  
24 be rather foolish if they were given the statement  
25 and they didn't look at it.

MR. HUNT: Oh, I think maybe the





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contrary.

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THE COMMISSIONER: Do you think your  
experience with witnesses is such that you think  
that wouldn't be strange at all?

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MR. HUNT: I would find that not  
strange in any circumstances.

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THE COMMISSIONER: Well, they  
wouldn't have much opportunity because Miss Cronk  
and her own counsel would be present and the  
statement would doubtless be read to them. That  
is the problem. If this statement is released  
then all statements have to be released to everyone  
and there are so many things on these statements.  
This is what is worrying me. They shouldn't be  
there - well, I don't say they shouldn't be there,  
a policeman has a right to ask any questions he  
wants but some of the responses are scandalous  
and I just don't want them released.

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MR. HUNT: First of all, I should  
indicate that what I want to do in seeing this,  
because I have statements that were taken by the  
Police that the Crown came into possession, I want  
to make sure that we are both dealing with the  
same document and if we are then I don't intend  
to make reference to anything that is scandalous





1  
2 in it, and that may be a separate issue as to  
3 whether or not it is relevant to deal with that.

4 THE COMMISSIONER: Well, no, if you  
5 can see it on the basis solely that she used it to  
6 refresh her memory then anyone can see it.

7 MR. HUNT: Oh, I agree.

8 THE COMMISSIONER: But I can't make  
9 a special order for you. I might, as I did in the  
10 case of Dr. Fowler, make a special order for Susan  
11 Nelles because he said something contrary to her.  
12 This is the real problem that I am faced with and  
13 I don't see that this -- I take it that you  
14 have a statement of some kind?

15 MR. HUNT: Yes. I suspect that  
16 what I have is the same as the one that the witness  
17 is referring to. But I intend to go into an  
18 area that Miss Cronk raised yesterday that involved  
19 this witness' discussions with the Police on a  
20 specific matter and before I do I want to make  
21 sure that I am not dealing with something that is  
22 different than what the witness was basing her  
23 evidence on yesterday.

24 MS. CRONK: I don't know, sir,  
25 whether it would assist or not but if that's the  
only present purpose for which Mr. Hunt wants to





1  
2 see the statement in the witness' possession, I  
3 know what I have, I know what Mr. Hunt has and it  
4 would be an easy matter for me to confirm whether  
5 or not we are talking about the same document that  
6 the witness has.

8  
7 MS. KITELY: Might I respond to  
8 that, sir.

9 THE COMMISSIONER: Yes.

10 MS. KITELY: I have a difficulty  
11 even with the solution proposed by Miss Cronk and  
12 that is that I understand while you hadn't made  
13 a firm ruling you had made one to the effect that  
14 the statements would only become an issue when the  
15 witness has said something that is prejudicial  
16 to a particular party.

17 THE COMMISSIONER: Well, you leave  
18 out the only. I am prepared to say "then does  
19 become an issue" when she says something contrary  
20 to a particular party. I am not too sure that  
21 that is so, that's why I was asking for one  
22 thing - what concerns me of course is not really  
23 so much Mr. Hunt's problem it is the problem that  
24 we are going to have with witnesses who have made  
25 statements or alleged to have had statements  
attributed to them which have inadmissible evidence







1  
2 within them, allegations against other people  
3 which are totally inadmissible and which I wouldn't  
4 allow to be given. Now, that is the real problem  
5 that I have and that is the basic reason why I  
6 hesitate to have these statements made available  
7 to everybody, that's all.

8 Now, in this particular instance I  
9 don't think that that is so. I don't think that  
10 that is so in this particular case. In any event,  
11 the witness has said nothing contrary to any  
12 individual party anyway that I can remember.

13 Well, if this were a criminal trial  
14 I wouldn't have any trouble with it at all but  
15 you wouldn't be the one who would be asking, it  
16 would be the accused.

17 MR. HUNT: I would be telling you  
18 why you shouldn't let anybody see it.

19 THE COMMISSIONER: That's right.  
20 I wouldn't have any trouble with it at all if  
21 this were a criminal trial, but it isn't a  
22 criminal trial, it is an Inquiry.

23 MR. HUNT: Well, I am quite content  
24 to adopt the solution that was suggested by Miss  
25 Cronk on this occasion because that would provide  
me with the assurance that I need before I can





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proceed any farther.

THE COMMISSIONER: No, Miss Kitley has objected to that. I think what I am going to ask you to do is to assume that they are the same without being told that and proceed accordingly because I haven't made a ruling on this.

Mr. Labow, you want to say something about this?

MR. LABOW: Mr. Commissioner, I should tell you now that I am going to make very similar representations to you when my chance to cross-examine comes up and I don't have any semblance of a statement from this witness to refer to.

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THE COMMISSIONER: Maybe you will know something about it by the time Mr. Hunt is through, I don't know. At any rate I am not going to order the statement produced yet, so, all right.

MR. HUNT: Thank you, I will proceed on that assumption, Mr. Commissioner.

THE COMMISSIONER: It is clearly something I'm going to have to give a great deal of thought and effort to because it is going to come up again and I don't really think it is a major crisis in this one but it may turn out-and I may have to have the witness back but I will take that chance. All right.

MR. HUNT: Q. Now, Mrs. Browne, you as I understand it spent more of your time dealing with the patients than you did with the nursing staff?

A. That is correct.

Q. And that would be true throughout this period from July of 1980 to March of 1981?

A. Yes.

Q. What I want to ask you is, in that period of time, did you find that in dealing with the parents concerning the deaths of the children, did you find you were having to confront







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an element of surprise on the part of the parents?

A. I can think of a couple of instances where I did.

Q. Did you find that this element of surprise that you had to confront related basically to the fact that the child died at a particular point in time?

A. In two instances.

Q. Is what you are telling me that only on two instances that you dealt with an element of surprise in your dealings with the parents?

A. In my memory, yes.

Q. In your memory. So in other cases there did not seem to be any issue of a death at an unexpected point in time as far as the parents were concerned?

A. That is a hard one to say when you are dealing with grief reaction.

Q. I appreciate there would be grief in every case, but I suggest to you that surprise is something that can accompany grief in a particular case where death was not expected at that point in time, although it may have been anticipated at some time.

A. That may be true, I think it





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the  
also depends on/parents understanding of what is  
going on with the child and understanding of the  
heart problem.

Q. Who were the two that were  
surprised?

A. Amber Dawson comes to mind,  
and Brian Gage.

Q. Did you deal with Mr. or Mrs. -  
the parents of Baby Pacsai?

A. No, Janet Beed did.

Q. Now, you told us about being  
approached at the end of July and again in mid-August;  
in July by Nurses Nelles and Trayner, and in mid-  
August by Nurses Nelles, Trayner and Bell. With  
respect to the deaths on the ward. You have indicated  
to my friends that this was appropriate that they  
come to you with these concerns?

A. Yes.

Q. My question to you is, had  
this ever happened to you before?

A. Yes.

Q. With respect to Wards 4A and 4B?

A. Yes.

Q. How many times?

A. It was seven and a half years'





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worth, that is hard to say.

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Q. Well, give it a try.

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A. I could say almost inevitably

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when there was a death on a ward indeed there was

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an approach and there was discussion around what

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had happened.

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Q. Well, I am concerned with the

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particular type of discussion that you have told us

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that you were involved in on this occasion, which as

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I understood it from your evidence involved not just

12

the deaths but questions about the cause of death.

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A. I would say that was more

marked at that point in time.

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Q. So your experience is that

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you have had nurses come to you with concern over

16

deaths. I take it that is not unnatural for nurses

17

to experience a particular grief over deaths when

they are involved in the care of that patient?

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A. That is true.

19

Q. But the thing that distinguishes

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what happened in July and August this time was that

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there was, in addition to what may be a basic

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element of grief over the situation, there was a

23

concern over the cause of death?

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A. Yes.

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Q. And had that happened to you  
before?

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A. In some situations.

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Q. I take it not as many situations  
as you were confronted with nurses who had problems  
over deaths of children?

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A. That is true.

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Q. Now, in July or August did  
any nurses, other than the three that we have  
mentioned, come to you with their concern about  
deaths?

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A. I can't recall specifically.

13

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Q. I take it that if someone  
else had it may well stand out in your mind just  
as the discussions with Trayner, Nelles and Bell  
stand out in your mind?

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A. It might, it would depend on  
the circumstances.

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Q. Dealing with the first occasion  
in July, I think you said this occurred in the  
morning?

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A. Yes.

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Q. Was it over coffee, or was  
this at a regular meeting, or an informal meeting  
between the three of you?

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A. It was an informal meeting at the change of shift as I started the day.

Q. Now we have heard sort of generally what was discussed. I am interested more specifically who said what. I appreciate this is going back some years, but can you indicate for us who led the discussion at that time, if anyone?

A. My recollection on one occasion was that Phyllis led the discussion.

Q. That was on one of the either July or August occasions?

A. Yes.

Q. You can't recall which one?

A. No.

Q. And how was the topic or the issue presented to you? Let's deal with July first of all if you can separate the two, if you can't, just say?

A. I don't think I can separate them.

Q. All right. How was the issue presented to you as far as you can recall the first time it was raised?

A. It was concerns about what had happened in the night that she was upset.





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Q. You say she, are you referring  
to Nurse Trayner?

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A. Is that what you wanted me to  
comment on?

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Q. Yes, just as long as we are  
on the same wavelength.

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A. Yes. Concern again about  
what had been done nursing-wise.

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Q. When you use the word "concern"  
which is a fairly general observation, can you be  
more specific as to what the nature of the concern  
was?

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A. I think I can only guess at  
the detail as I have been already, in terms of the  
concerns about their nursing observations, reviewing  
what they had done; what signs they had that things  
were not well with the baby; what they had done  
with that in terms of alerting the medical staff.

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Q. Were you asked in effect to  
review the events leading up to the death of the  
baby with a view to commenting on the adequacy of  
the response of the nurses?

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A. In a general sense not from  
recorded information, but from their discussing what  
had happened.





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Q. And it was with a view to having you comment on the adequacy or the appropriateness of the treatment given?

A. Yes.

Q. How long did those discussions take?

A. 15 or 20 minutes, maybe.

Q. And I take it that a good portion of that time was spent discussing the events leading up to the death of the child, and the clinical history of the child at that point in time?

A. Some, almost more time was spent around theories.

Q. In the course of the discussion was there anyone who took part more than anyone else? You have indicated that you recollect on one occasion Nurse Trayner led the discussion, is that your recollection of both meetings?

A. Both meetings I have trouble separating because it wasn't just with one nurse, it would be who was joining in, because it was in the open space of the nursing station.

Q. Well, is what you are telling us then that your recollection of the meetings is







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that Nurse Trayner led the discussion?

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A. On one occasion.

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Q. But you can't separate the

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two occasions?

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A. I can remember one occasion

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where she led the discussion.

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Q. And then you have no recollec-

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tion as to who led the discussion, if anyone, on  
the other occasion?

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A. They were more general

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discussions as I recall.

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Q. On the occasion when Nurse

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Bell was present, was that by pre-arrangement, or

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did she just happen to be there when the discussion  
took place?

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A. She happened to be there,

16

she was the team leader on the 4B side, so again

17

she was a logical one to be in the nurses' station

18

finishing up her work at that time of the morning.

19

Q. So basically the people who

20

sought you out on both occasions were the same two,

21

Trayner and Nelles, and on one occasion Nurse Bell

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happened to be present because of the location where  
this discussion took place, is that fair?

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A. Yes.

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Q. Now, you mentioned that in addition to stress and concern that was causing difficulty to the Trayner team, that there were conflicts or a conflict of some sort that existed. I took it that you meant with respect to that particular team?

A. In the context that it was raised, yes.

Q. Can you just elaborate on what you meant by conflict.

A. Well, can I say it wasn't firsthand involvement around the issue of conflict, it was my awareness in discussion with the head nurse.

Q. I am sorry, it was your own awareness?

A. It was awareness raised by the head nurse.

Q. Awareness that you were made aware by the head nurse of the conflict, because I take it of your role as a liaison person really?

A. Yes.

Q. What was the nature of the conflict that you became aware of?

A. I didn't feel that it was





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particularly unusual for any group of people working together in a stressful situation.

Q. You can comment on it afterwards if you could, but just tell me first what the nature of the conflict was?

A. My understanding of it at that time was that some difficulties in working together in the sense of trusting one another on the team, and in terms of delegating or respecting the role of the other.

Q. Anything else?

A. That is all I can recall.

Q. Did this conflict involve any of the members of the team?

A. Primarily it was identified as involvement between Phyllis Trayner and Susan Nelles, but indeed that affected the whole team.

Q. So that I have it straight, the conflict as you understood it involved just the two nurses, but I suppose of necessity the fact of the conflict had some effect on the whole team?

A. That is correct.

Q. Now this conflict with respect to trust, and delegation of authority of respect, when did you become aware of the existence of it?





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A. I believe it was the fall.

Q. The fall of 1980?

A. Yes.

Q. Do you recall when in the fall?

A. No.

Q. And at the time that you became aware of it, do you know how long the conflict had existed?

A. I think I had assumed that that was a part of their coming together as a team with the move from the fifth floor to the fourth floor.

Q. Which occurred some time in the spring?

A. April.

Q. In April?

A. Yes.

Q. So you heard about it in the fall and at that time you were under the impression that it had existed for some number of months prior to that point in time?

A. Yes.

Q. Now, at the time that you were made aware of it were you given any specific information by way of an example of the manner in which the







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conflict may have manifested itself?

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A. Not that I remember, no.

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respect?

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A. No.

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Q. Did you ever discuss the  
conflict with either or both of the two nurses?

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A. No.

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Q. Did you ever discuss the fact of the conflict with anyone else? I mean, was this viewed as the sort of problem that you would take to someone that you dealt with?

A. No, it was being handled by the head nurse.

Q. Who was the head nurse who was handling that?

A. Liz Radojewski.

Q. Now, by October, mid or late October, the concern that you have discussed with us over the deaths of babies had been reigning for approximately three months?

A. Yes.

Q. And that is the point in time when we noticed in the records yesterday, I think Exhibit 300, the reference to obtaining some psychiatric counselling for the nurses?

A. It was raised at that point, but it had been raised the middle of August.

Q. So the first time that came up was the middle of August?

A. Yes.

Q. The next time it came up was October?





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A. Yes.

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Q. In the interim, as far as you are aware, no steps were taken to arrange for that psychiatric counselling?

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A. My understanding was a request had been made for that and the outcome of that request was that a psychiatrist was made available on a limited basis for certain children and families on the ward.

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Q. Now, you indicated to my friend, Ms. Forster, that psychiatric counselling for nurses was not something that was unheard of in your experience?

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A. That is correct.

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Q. Had it been done before on Wards 4A and 4B or the predecessor cardiac ward?

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A. I think we had on one or two occasions, and it had evolved out of consultation with one of the psychiatrists around a particular child, but it was not an organized --

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THE COMMISSIONER: What about the psychiatrist that came to the ICU, would he not be available to any nurse who wanted to see him?

THE WITNESS: No, it was an arrangement, it was an outside psychiatrist that came in for





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that specific purpose for their staff.

THE COMMISSIONER: Just for the ICU?

THE WITNESS: Yes.

THE COMMISSIONER: Yes, all right.

MR. HUNT: Q. All right. Now, you have indicated that you think it had occurred on one or two prior occasions with respect to the cardiac ward?

A. Yes.

Q. Do you recall when?

A. I recall it in terms of 5A. I cannot put it in terms of date.

Q. All right. On the occasion or occasions where it had happened before, to your knowledge, it arose as a result of a need for counselling over the death of a patient?

A. Not necessarily the death of a patient, no.

Q. All right. I do not want you to speculate on what it was because this may be of some significance, this whole area, but can you try and be as precise in your recollection as you can as to when before and with respect to what nurses in the cardiac ward received psychiatric counselling?

A. The two situations that come to







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mind were children who were in the hospital for two or three months, and it was not around death of those children but it was around the stresses and problems related to a prolonged hospitalization for the child and the family.

Q. So on the other occasions we were dealing with, the issue arose as a result of stress that was associated with simply prolonged hospitalization of very sick children?

A. Yes.

Q. This occasion, by October, was involved with the deaths now of a considerable number of patients where there was concern over -- where there was the stress involved with those deaths as well as concern over the cause of death?

A. Yes.

Q. All right. Now, that particular type of problem, I suggest to you, was unprecedented by mid-October in your experience?

A. I would have to say yes in terms of 4A/B.

Q. Well, is there any reason why, to your knowledge, the idea of psychiatric counselling was not picked up on between August when it was raised and October?





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A. I do not know why.

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Q. You have indicated that ultimately it did not start, that is, counselling of nurses, until April?

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A. That is correct.

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Q. Which was after obviously the events of March that we have been concerned with for so long in this Commission?

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A. Yes.

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Q. Between October and April, to your knowledge, was the question of psychiatric counselling raised again or carried any further than it had been by October?

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A. It was raised again, I believe, in December, and I would refer to the communication book for that time. The question was raised whether we would approach Andrea Frewin, who was a mental health nursing consultant in the hospital, to provide a similar service, and it was raised again in a meeting in January and would be taken to the team leaders of both 4A and 4B to decide if they would be willing to go that route.

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Q. Well, did that take place?

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A. No.

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Q. Was there some reason why -- I





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guess what I am looking for is why something did not  
happen with respect to these requests.

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A. My understanding when it was  
raised in January was that it would be taken to a team  
leader day, a day set aside to discuss management  
issues on the ward, and that took place March 10th.  
I cannot tell you the outcome of that in terms of  
whether the team leaders decided that yes, they would  
like Andrea Frewin to be available to them or not.

Q. Now, did you at some point in  
time form an impression, as the concern about deaths  
continued, that the deaths were happening in the  
presence of one particular team?

A. Not really until the fall.

Q. Did you form an impression at  
some point in time that the deaths, in addition to  
occurring in the presence of one particular team, were  
occurring during the nighttime or a particular period  
in the nighttime?

A. Not consciously until March of  
1981.

Q. Now, the discussion about  
splitting the team up, again I think we saw reference  
to that in the fall in the notes for October?

A. Yes.





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Q. Was that the first time that that particular response to the situation was discussed?

A. Yes.

Q. Now, I was not clear on your answer yesterday. Was this discussion about splitting the team up centred on just the Trayner team or was it all of the teams who were involved?

A. It was all of the teams because if you split one team then you reorganize the other teams.

Q. Well, you could split one team without necessarily involving all of the other teams. I appreciate that you need to involve at least one other team, but --

A. Okay.

Q. I am trying to get a feel for just how general this split up or reorganization was thought to be or how general it was as it was discussed at that point in time.

A. Could you ask that again, I am sorry?

Q. How general was the reorganization that was being discussed at that point in time?

A. How general in terms of impact







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on all the nurses?

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Q. In terms of all the nursing teams on 4A and 4B.

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A. I think all of the nurses looked at it as potentially affecting them.

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Q. Would it be fair to say that what you had by October was concern about the deaths that were happening with respect to patients that the Trayner team was looking after, the stress that those particular nurses were under, and a considered response to the situation of splitting up that team with whatever impact or effect that might have on one or more of the other teams?

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A. Yes.

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Q. But essentially, the concern was was it a good idea to split up the Trayner team?

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A. I would say that was the base of it, yes.

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Q. Now, does that sort of thing often happen in your experience? I do not mean just reorganizing a team because somebody leaves the hospital or somebody goes somewhere else, but where in response to a particular situation the team is split up?

A. I guess I would say not in terms





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of response to a situation, but there are situations arise where there is conflict within a team and one option for resolving that conflict is to change the components of the team.

Q. Well, this team, as you have already indicated, had conflict surrounding it, at least in terms of Nelles and Trayner?

A. Yes.

Q. In addition, it had the situation as it prevailed in October regarding the concern over the number of deaths that had happened since July and the concern over the cause of some of those deaths?

A. Yes.

Q. What was the reason why the team was not split up? I mean, I am looking at it from an outsider's point of view, and it seems to me to be a fairly reasonable suggested response to the situation that prevailed in October, and why did it not happen?

A. I think their response was not unlike the response of other teams, that there had been a fair bit of reorganization happen with the change to the 4th floor in April. There had been a fair staff turnover through that period into the summer, and so people were really feeling the need of





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establishing stable teams and feeling secure with the other members of the team. So they were just beginning to establish that, so to think of upsetting that did not sit well with any of the teams.

Q. Well, was there some concern on the part of other teams of not wanting to have members of the Trayner team on their team?

A. I did not pick that up at all, no.

Q. Well, whose decision would it have been to split the team up or not split it up?

A. It would have been the head nurse's decision.

Q. That is Liz Radojewski?

A. Yes.

THE COMMISSIONER: Who was at that meeting? I have lost track of the meeting now, but --

THE WITNESS: It was the meeting at Meredith's on October 23rd.

THE COMMISSIONER: Can you find it for me quickly?

THE WITNESS: I should be able to.

THE COMMISSIONER: It does not matter whether you can do it quickly or not.

MS. KITELY: Mr. Commissioner, it is





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Exhibit 301 at page 8.

THE COMMISSIONER: I probably have it here.

THE WITNESS: Thank you.

THE COMMISSIONER: The reason I ask is that although -- at least I think I am right on this, although Mrs. Trayner appears to be there, was Miss Nelles there at that meeting?

THE WITNESS: Not as recorded, no.

THE COMMISSIONER: The fact that it says somewhere, where is the reference to not --

THE WITNESS: It is at the very beginning, sir.

MS. KITELY: Right after the date, sir.

THE COMMISSIONER: We do not need our team to break up.

THE WITNESS: Yes.

THE COMMISSIONER: Was that not a statement made by the team leader of 4B?

THE WITNESS: Yes, it was.

THE COMMISSIONER: Well, does it apply to both teams? Sorry, were you there?

THE WITNESS: Yes, I was.

THE COMMISSIONER: You were there?

THE WITNESS: Yes.







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THE COMMISSIONER: Then you can help us  
by telling us was it both teams that wanted to stay  
together or was it just 4B?

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THE WITNESS: It was a meeting of both 4A and 4B staff and the general feeling was that none of the teams wanted to be split up.

THE COMMISSIONER: Well, in some senses would the two teams consider themselves one at all?

THE WITNESS: In some sense, perhaps at that time because a lot of the staff had worked together as a team prior to this time.

The other thing perhaps to clarify in terms of the 4A and 4B involvement because indeed the wards were so close together and shared a common nursing station, if you were short on 4A, 4B staff would help out if they could. So, it was that kind of a supportive arrangement.

MR. HUNT: Q. Well, inasmuch as the team wasn't split up at that point in time, I take it that there wasn't any concern about the adequacy of the nursing care that the team was able to deliver to the patients?

A. That is correct.

Q. Because if there had been that kind of concern I take it something would have been done?

A. Yes.





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Q. So, in October it wasn't felt that this team was the sort of team who would make a lot of mistakes and put the health of the patients in jeopardy?

A. That is correct.

Q. Now, did a point in time come when other nurses or other nursing teams became concerned and expressed to you about the amount of time and concern that was being focussed on the Trayner team?

A. Yes.

Q. When did that happen?

A. Oh gosh. I honestly can't tell you if it was the fall or the spring.

Q. All right. From that, I draw the inference that the concern about the situation that the Trayner team was in in terms of these deaths and the concern over them and the stress, wasn't something that was simply a matter of discussion at these meetings, these few meetings that we see recorded in the books, but this was something that was - it was a fact of life on a day-to-day basis right through this whole period?

A. Certainly the other teams were aware of it, yes.





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Q. And this commenced some time I would think prior to October, this feeling that there was a problem and one that required a certain amount of time and discussion to finally resolve?

A. Yes.

Q. And this started going back in the summer of '80?

A. Yes.

Q. Continued right through to March of '81?

A. Periodically, yes.

Q. All right.

THE COMMISSIONER: Well, you say the other teams. My last note here was that the complaint didn't take place until the spring and of course the spring is after March 21st. You say that there were some awareness, some discussion with the other team?

THE WITNESS: Some concerns raised by other members of other teams.

THE COMMISSIONER: About what?

THE WITNESS: About the time and attention that ~~was~~ given to that particular team.

THE COMMISSIONER: Well then, I am wrong about the spring, it wasn't, it was from







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the beginning?

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THE WITNESS: Yes. I just can't pinpoint at exactly what time that feedback came from other members.

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MR. HUNT: Well, I am trying to get a feel for the atmosphere as it existed at the various points in time but certainly from the summer of '80 through to March of '81 insofar as the problem that the Trayner team was in is concerned and the inference that I draw from this is that this was an issue that was certainly well known to everybody working on the cardiac wards 4A/4B?

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A. Yes.

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Q. It was an important one in the sense that it was a serious problem for those who were suffering from the stress of the situation?

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A. Yes.

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Q. It was one that required or one about which there was constant discussion and thinking with respect to how to resolve the problem?

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A. I would have trouble with the constant.

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Q. All right. But I mean certainly more than we see reflected just in the





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few notes of the meetings that were gone through  
yesterday?

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A. Yes.

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Q. It was a fact of life on a  
day to day basis that the problem existed?

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A. It existed. I don't know  
about day to day.

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Q. Well, it never went away  
after it started in the summer, did it?

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A. Well, I would say that we  
went through definite periods where that was not  
the biggest issue.

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Q. All right. But in terms of  
the people who were suffering from the stress of  
the situation, it never went away for them from  
the point in time where it started in the summer  
through until March?

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A. Yes, that would be true.

Q. All right. Now, you were  
asked by my friend Miss Cronk yesterday about your  
discussions with the Police in July of 1982?

A. Yes.

Q. And we had reference to an  
interview between you and the Police on July 9th.

A. That is correct.





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Q. 1982. And this is I think what I am assuming we are both dealing with here are the notes of that particular interview?

A. I only have notes from one interview.

Q. All right. Now, I took from what you said to Miss Cronk yesterday that there were certainly two pieces of information that you gave to the Police on that occasion; one was that you couldn't accept the idea that all of the deaths that had occurred in the period from July of '80 to March of '81 were deaths from natural causes?

A. Can I preface that indeed I was asked to speculate and that supposedly was off the record.

Q. All right.

A. Please ask again.

Q. We will get to that because I know that you are concerned that it was off the record and that it involved speculation and I will give you every opportunity to comment on that. But first, can we just clarify what it was that you told the Police, and I am suggesting that you gave them two pieces of information at the time. The first one was that you couldn't accept the idea





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that all of those deaths were from natural causes?

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A. Given the levels of digoxin that had been reported both in the paper as well as by hearsay in that time, yes.

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Q. All right, we are going to get to what qualifications you have told the Police on that occasion because that is the purpose of me going back here because I am going to suggest to you that you didn't qualify your responses to the Police at that point in time the way you qualified them here yesterday. So, can we go through it from the start and first of all let us try and get straight what you told the Police?

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A. All right.

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Q. The first thing I am suggesting that you told them was that you couldn't accept the idea that all of the deaths were from natural causes?

A. That is correct.

Q. All right. The other thing you told them was that you were concerned about the possibility of an unbalanced person walking around on the ward and why that hadn't been noticed before it was and you put some of the blame on yourself for not noticing the odd goings on?







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MS. KITELY: Mr. Commissioner,  
might I rise before the witness answers the question?

THE COMMISSIONER: Yes.

MS. KITELY: In some ways I am at  
a loss how to deal with this. My friend purports  
to put a quotation to the witness.

THE COMMISSIONER: Well, no, but he  
is asking her what she said to the Police. Surely  
he is entitled to do that.

MS. KITELY: But assuming he has  
a record.

THE COMMISSIONER: Well even if he  
hasn't. If he hasn't he can put to her that this  
is what you said. He may not have a record at all,  
he may have been told by the Police that this is  
what she said.

MS. KITELY: Well, might I indicate,  
sir, that part of what my friend has just said is  
not included in the statement to which we are all  
referring to.

THE COMMISSIONER: Well, no, you  
must not assist the witness. You see, you must  
allow Mr. Hunt to cross-examine. He is putting  
it to her that she has said these things to the  
Police. Now, if you want to turn over the document





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2 to him, which I thought you didn't want to do,  
3 it may be that it is a different document from the  
4 one he has, I have no idea, but at any rate he is  
5 trying to cross-examine now and he is cross-examining  
6 her on what she said to the Police. If she said  
7 something to the Police that is different than what  
8 she has said now it is --

9  
10 MS. KITELY: . Then is my friend going  
11 to prove that she said something differently later  
12 on.

13 THE COMMISSIONER: No, no, he doesn't  
14 have to. Well, he doesn't have to, that is the  
15 issue. You don't have to prove that.

16 MS. KITELY: Thank you, sir.

17 THE COMMISSIONER: It is something  
18 that goes to her credibility generally. I have  
19 never known that this had to be proved that she  
20 said something differently. He may want to  
21 do it, he may want to do it, but surely he has a  
22 right to cross-examine by asking her if she did.

23 MS. KITELY: I have nothing further  
24 to add, sir.

25 THE COMMISSIONER: No, all right.  
All right, well, carry on now, please.

THE WITNESS: May I ask if I could





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refer to the document at the same time?

THE COMMISSIONER: Certainly, I don't see any objection to that.

THE WITNESS: Thank you.

MR. HUNT: Q. Page 9, Miss Browne. I am assuming that we are dealing with the same document. Take your time. If on your page 9 there is a question about a third of the way down, take your time and just read it from that point on.

MR. OLAH: Mr. Commissioner, I notice that my friend has called for production of the document. Does that now mean that it becomes evidence. The general rules of evidence are, as I understand it, when an examiner or someone calls for the production of a document it then becomes available to all parties.

THE COMMISSIONER: No, that is not my general rule. He is saying you have a document, you have a document, you may look at it. He hasn't called for it. What he has said now was, he is asking at the moment, now, what did the witness say to the Police.

MR. OLAH: No, but my friend Miss Kitley has called for it and I am suggesting that





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2 at that point the document becomes admissible and  
3 available to all parties.

11 4 MS. KITELY: I don't know that I  
5 have, sir. The witness simply asked to have a look  
6 at it.

7 THE COMMISSIONER: Yes, the witness  
8 wanted to look at it and I don't think that any  
9 fatal step has been taken by anybody. But it all  
10 adds up, it all adds up.

11 Yes, all right. Now, you have had  
12 an opportunity to read page 9 and any other page  
13 you want to read?

14 THE WITNESS: Yes.

15 THE COMMISSIONER: All right, now,  
16 Mr. Hunt, please.

17 MR. HUNT: Q. Now, do you want me  
18 to repeat the question, I guess that would be a  
19 natural request.

20 A. Yes, please.

21 Q. I am suggesting to you that  
22 the second thing that you told the Police or piece  
23 of information that you gave them was that you were  
24 concerned about the possibility of an unbalanced  
25 person walking around up on 4A and 4B and why she  
wasn't noticed and you put some of the blame on







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yourself for not noticing the odd goings on?

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A. That is correct.

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Q. Now, those pieces of  
information were given to the Police in July of  
1982 in response to the question 'what do you  
think happened up there?', referring to 4A/4B?

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A. That is correct.

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Q. And I am suggesting to you  
that at no point did you add to the Police all  
of these qualifications that you included in your  
answer yesterday, and to be fair I will just read  
it to you. Well, actually, it is quite lengthy.  
Let me just suggest to you that at that point in  
time what you were giving the Police was your re-  
action in response to their question and it was  
given without - it was an honest reaction given  
by you without qualification?

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A. I have trouble saying that  
because in the transcribing of this, and it was a  
very laborious interview in that the person record-  
ing was writing things out longhand and there are  
many parts of this document that don't make sense  
and some of the comments that are written down here  
are totally disconnected from anything previously.  
There may be times when I don't connect well but





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I don't believe that this is an accurate representation of what was said at that time.

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Q. We have sort of isolated two things that you agree were accurate?

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A. Yes.

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Q. All right. And they appear to accord pretty well with what is on the statement.

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A. Out of context, yes.

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Q. I am putting it to you that what in fact happened was that you were asked for your opinion as a person who was on the ward dealing with the nurses in the capacity that you were, dealing with the parents, what do you think happened up there, and you gave the police those two pieces of information without reference to assuming there was digoxin, and assuming the levels were accurately tested by the Centre of Forensic Sciences, and assuming the other qualifications that you referred to yesterday. You gave them those responses without any of that.

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A. I am not sure that that is true because of the accuracy of the recording.

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Q. All right, you tell me what qualifications, because we will hear from the officers.

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A. Yes.  
Q. You tell me what qualifications you put on your opinions in response to the question "What do you think happened up there?".

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A. I believe the discussion did focus around that period of time and the results of what had come out of the preliminary, what had been in the press, and looking back on things. It was very much speculative but I do believe at that time





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that I did talk about dig. levels, and had trouble explaining digoxin levels as natural, if indeed they were as elevated as they ---

Q. Well, at that point in time I am suggesting to you that in July 1982 there was not any question about the levels of digoxin not being accurate.

A. But ---

Q. Just after the end of the Preliminary Hearing, just after Judge Vanek had found that four children on 4A/4B were murdered; and in July of 1982 none of the questions that this Commission has been dealing with in the last six months had even begun to surface. So what was the issue that you felt required you to qualify your answer based on digoxin?

A. My difficulty believing that that was the case.

Q. So you had difficulty believing that there were, that there could be murders in the Hospital?

A. That is correct.

Q. And you are not alone in that difficulty. I am not suggesting that that is inappropriate, or unreasonable. As I have said one







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of the pieces of information was that you said you don't think you can accept the idea that all the deaths were from natural causes. I am not suggesting that you told the police anything definite about it. I am just saying you didn't qualify it with all of the concerns about digoxin that this Commission has been concerned with.

A. I didn't qualify it in terms of what was recorded.

Q. And the third piece of information that you gave to the police at that time was, that after thinking about it, that is after thinking about the fact that you just didn't think you could accept all of the deaths were from natural causes; after thinking about it you have trouble accepting that it, that is the deaths, the cause of death, was other than nursing care.

A. That is what is stated.

Q. That is what you told them?

A. Yes. I told them that it was other than nursing, I didn't saying nursing care.

Q. Okay. I'm not trying to lead you to make an issue of the care, or the adequacy of the care.

THE COMMISSIONER: Would you have





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difficulty believing it was other than nursing?

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THE WITNESS: Yes, yes.

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THE COMMISSIONER: You had difficulty  
in believing what, that the cause of death was other  
than nursing?

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THE WITNESS: If indeed dig. levels  
were high and someone had purposely done something.

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THE COMMISSIONER: Remember you are  
being asked what you said, not what you thought, or  
what you think now. You are saying what you think  
you said, is that right, to the police?

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THE WITNESS: Yes.

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THE COMMISSIONER: That if the  
digoxin levels were high, the deaths ---

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THE WITNESS: Yes.

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THE COMMISSIONER: And I take it  
you assume they were high at that time?

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THE WITNESS: In specific situations.

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THE COMMISSIONER: Everybody seems  
to. Well, they were not high, there was no readings -  
those that were taken were high.

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THE WITNESS: Yes.

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THE COMMISSIONER: Those for  
children certainly anyway.

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THE WITNESS: Yes.

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THE COMMISSIONER: Then what was  
it you said to the police, that if it were what,  
if the digoxin levels were high?

THE WITNESS: Yes.

THE COMMISSIONER: And if the  
children died from that cause?

THE WITNESS: Yes.

THE COMMISSIONER: Is that what  
you mean?

THE WITNESS: Yes.

THE COMMISSIONER: That what?

THE WITNESS: That I had trouble  
believing it was other than nursing.

MR. HUNT: Q. To put it the other  
way, what your feeling was that given all those  
facts you believed that it must have been someone  
connected with nursing?

A. I felt that nursing was in  
the position to have access to the children.

Q. That is what I wanted to get  
to. Because, if we just consider for a moment, sort  
of the classifications of people that are - that  
could have the kind of opportunity to do something  
like this, we have, I suppose the first group would  
be strangers?





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A. Yes.

Q. And I take it that really it is so unlikely that we can discount it?

A. I would agree.

Q. Because a stranger on the ward is going to attract attention?

A. Yes.

Q. And I don't know, is 4A and 4B one of the wards where people going into the rooms have to put on a gown?

A. No.

Q. But people would know who belonged there and someone who didn't is going to stand out?

A. Particularly at nighttime, yes.

Q. So we are then left with staff, so in terms of support staff and medical staff?

A. That is correct.

Q. And I take it that at night-time the support staff generally was not around?

A. True.

Q. And my question is this; with respect to the medical staff was there some reason







G7 1  
2 why as between doctors and nurses you had trouble  
3 accepting that it was other than nurses?

4 A. A good number of the children  
5 noted in the time period were under constant nursing  
6 care so the nurse would be there all the time.  
7 So that if a doctor were to come and go that would  
8 be known to the nursing staff.

9 MR. HUNT: Thank you, those are  
10 all the questions I have.

11 THE COMMISSIONER: Yes. You are  
12 next?

13 MR. YOUNG: I am, Mr. Commissioner.

14 THE COMMISSIONER: I seem to have  
15 lost track, I guess you are next.

16 CROSS-EXAMINATION BY MR. YOUNG:

17 Q. Good morning, Ms. Browne,  
18 I am David Young and I am one of the lawyers  
19 representing the Metropolitan Toronto Police here.

20 We have spent quite a bit of time  
21 talking about statements that you gave to the  
22 Metropolitan Toronto Police in the summer of 1982.  
23 Tell me, did you make any other notes about what  
24 went on in the Hospital during the period we are  
25 interested in?

A. No.





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Q. You didn't make them during  
that period?

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A. No.

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Q. And you haven't made any since?

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A. No.

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Q. Mr. Hunt finished off his  
cross-examination, and there was discussion between  
you and he about constant nursing care. This was  
also discussed last Thursday when Ms. Cronk was  
examining you. For the assistance of your counsel  
and the Commissioner I refer them to Volume 82,  
page 7778, actually the discussion goes right  
through to page 7780. Rather than reading over all  
of that, I am sure your counsel will correct me if  
I misinterpret this. It appears that you told the  
Commissioner that there was a backup nurse assigned  
whenever there was shared or constant care nursing?

18

A. That is correct.

19

20

21

Q. And this nurse would have  
been assigned in advance I imagine?

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A. At the beginning of the shift  
usually.

Q. And who would have assigned  
that nurse, would it be the team leader?

A. It would be the team leader.





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Q. And actually it was the team leader who actually was the backup nurse, is that right?

A. Often, yes.

Q. Where was the identity of this individual recorded, the relief nurse, where would I look to find out who was a relief nurse at any given time?

A. I don't think it was recorded anywhere, but you might direct that more accurately to the head nurse.

Q. All right. While we are talking about constant nursing care I would like to confirm exactly what you feel constant nursing care is and particularly what it was during the period in question. I know that this question was put to you by Ms. Cronk, and once again I refer my friends and the Commissioner to Volume 82, page 7779. I think on this occasion that perhaps I should read that to you. It is towards the bottom of the page, and you were asked by Ms. Cronk:

"Q. Could you as well explain from a nursing perspective what was involved in constant care nursing care duties?"





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And your answer was:

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"A. Constant care nursing meant  
that one nurse was assigned to one  
child and that there would always be  
a nurse with that child.

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Q. Was the nurse who was assigned  
constant care duties responsible again  
for the total care of that patient?

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A. Yes."

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Is that an accurate description?

11

A. Yes.

12

Q. Do you know a Shirley Anne

13

Parcels?

14

A. Parsons?

15

Q. Parcels, P-a-r-c-e-l-s, I believe

it is spelled.

16

A. Not well.

17

Q. Do you know who she is?

18

A. She was one of the nurses on

19

the ward.

20

Q. On which ward?

21

A. I believe on 4B.

22

Q. And was she a nurse during

the time that we are examining?

23

A. I can't say specifically the

24

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time.

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Q. Was she a competent nurse,  
did you have any dealings with her that would  
indicate one way or the other that she was competent?

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A. I didn't know her well, I  
would rather reserve comment.

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Q. Well, Ms. Parcels gave evidence  
at the preliminary hearing involving Susan Nelles  
and she gave evidence on February the 18th, 1982.

Mr. Commissioner, this is in Volume 20  
at page 29.

12

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THE COMMISSIONER: I don't have  
this, if you are going to read very long, or are you  
going to read a great deal?

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MR. YOUNG: No, I was hoping to  
summarize, Mr. Commissioner.

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THE COMMISSIONER: Yes, all right.

MR. YOUNG: My friend has asked  
my indulgence and I am waiting for her to get the  
volume.

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THE COMMISSIONER: Well, we could  
take a break now I suppose.

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MR. YOUNG: Well, with respect,  
Mr. Commissioner, I am going to be some time but I  
wonder if I might finish this discussion of constant





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care nursing.

THE COMMISSIONER: Yes, by all means.

MR. YOUNG: Then I will be happy  
to break.

MS. KITELY: If my friend will  
allow me to lean over his shoulder while he looks --

MR. YOUNG: I will do better than  
that. I will give my friend the transcript.

MS. KITELY: Thank you.

THE COMMISSIONER: Yes.

MR. YOUNG: Q. It appears that  
Ms. Parcels was asked a very simple question. She  
was asked to describe constant care nursing, and  
it appears to me from reading through that that she  
gave a somewhat different answer than you did,  
Ms. Browne.

Would it surprise you to learn that  
in her description of constant care nursing she  
indicated that she was, she had on many occasions  
seen nurses turn on the intercom, leave the room  
and go to the nursing station?

A. Yes, that would surprise me..

Q. But it appears that Nurse  
Parcels had seen that because she said that under  
oath. You have never seen that, have you?





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A. No.

Q. Have you ever heard of it?

A. No.

MR. YOUNG: Mr. Commissioner,  
perhaps this is an appropriate time?

THE COMMISSIONER: All right. Then  
we will take, I can't see it is the lights, is it  
5 past 11:00?

MR. YOUNG: Yes, it is.

THE COMMISSIONER: We will take  
until 25 past. Is there some problem about them  
downstairs because people don't seem to be able to  
come back in time, is there a difficulty?

MR. YOUNG: There shouldn't be,  
Mr. Commissioner.

THE COMMISSIONER: All right. We  
will try it once more.

THE WITNESS: I will assure you  
I will be back in time.

MS. CRONK: That was not directed to  
you, Ms. Browne.

---Short recess.

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--- Upon resuming:

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THE COMMISSIONER: Yes, all right,  
Mr. Young.

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MR. YOUNG: Q I understand the  
witness has something to say about the last answer  
she gave?

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A. If I could just go back to the  
comments about constant care nursing and the reference  
that was made to evidence given by Miss Parcels in  
the preliminary.

10

11

Q Yes.

12

A. I would just like to emphasize  
in the documentation of her testimony she commented  
that there would be situations where if the child  
was on a cardiac monitor the nurse on constant nursing  
care will turn up the intercom so as to be able to  
hear the monitor, leave the room and go to the nursing  
station where she indeed could hear the monitor.  
She goes on to say that it might just be to go across  
the hall to the fridge to get formula. I would like  
to comment that in situations --

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Q Well -- I am sorry, go ahead.

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A. Okay. In situations where the  
nurse was doing constant care in a four-bed room,  
there generally was another nurse in the room, so that

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did not pose the same problem. If the nurse was doing constant care in a private room there was a call bell in the room with which she could call to the nursing station to either request that another nurse bring her what she needed to the room or come to relieve her while she went out to get something. As the comments went on, again, the question was raised:

"Regardless of what the rules are at The Sick Children's Hospital, during your experience there, constant care nursing really didn't necessarily involve constant nursing care, practically speaking, did it?"

And her answer was:

"To some people, not."

Q. Yes, can you keep reading? Read the next few lines.

A. The next question then was:

"To some people not?"

And the response was "Correct", and the next question was:

"Certainly not to Sui Scott and Phyllis Trayner to your observation?"

The answer was "Correct".

Q. I have one other question on





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that area for you, Ms. Browne. How often did you work the late shift in evenings? Over a week, how many times a week would you work in the night?

A. Into the evening?

Q. No, I am speaking of two, three in the morning, four in the morning?

A. Never.

Q. You never did. So you really would not know whether or not nurses left the room, turned on the intercom and went out to the nurses' station, do you?

A. That is correct, in a practical sense.

Q. All right. Let us move on to something else that was discussed earlier, and that is medication errors. Tell me, once a medication error is discovered, if it is discovered, what is the response of the Hospital?

A. The incident report that is filled out by the nurse involved in the drug error and by the head nurse, then to my knowledge goes to a review committee. Out of that review committee then recommendations are made for policy change or specific changes either in orientation or approach to giving medication.





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Q. How many copies of this incident report were made?

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A. I think it comes in three or four duplicates with the one recording.

5

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Q. Could you assist the Commissioner in where these copies end up?

7

A. No, I cannot, I am sorry.

8

Q. Do you know where any of them go?

9

A. To the review committee, but apart from that, no.

10

11

Q. Now, we heard yesterday about four incidents involving drug errors relating to digoxin administration. Do you know if any of these drug errors related to Baby Gage? That does not ring a bell?

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A. I do not know that.

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Q. I am showing you a document that appears to be a patient incident report; is that what it looks like?

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A. Yes.

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Q. Could you tell the Commissioner what child that relates to?

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A. Brian Gage at the top.

22

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Q. Yes. Have you seen this report before?

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A. I do not believe so.

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MR. YOUNG: Mr. Commissioner, we have a bit of a problem here. I have this document and I am willing to tender it as an exhibit. It is not identified. It certainly relates to one of the children we are examining.

I suspect that someone at a later date will be able to identify it, and I suggest that it be marked as an exhibit at that time.

THE COMMISSIONER: Have you any thoughts on that, Ms. Thomson?

MS. THOMSON: Mr. Commissioner, I have not yet seen this document.

THE COMMISSIONER: No, I think it would be best to let Ms. Thomson take a look at it first.

MR. YOUNG: All right, I only have a limited number, but perhaps you could share with the witness.

MS. KITELY: Does my friend have any more copies?

MR. YOUNG: I have three copies. I gave one to Ms. Cronk, one to the witness and I have a copy.

THE COMMISSIONER: Have you any comments?







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MS. THOMSON: It would seem, Mr.

Commissioner, that this is an incident report much like Exhibit 113A, which was admitted on the Inwood child. We have no objection to it being received.

THE COMMISSIONER: Well, I think we will just give it -- what is the next number then?

THE REGISTRAR: 308.

THE COMMISSIONER: 308. If anybody disputes it you may have to prove it, but so far no one has disputed it.

--- EXHIBIT NO. 308: Incident Report regarding Brian Gage.

MR. YOUNG: Q All right. Now, could you help me with this, Ms. Browne. You are likely much more familiar with this sort of document than I am. It seems to say part ordered ---

THE COMMISSIONER: That is the only copy we have left. I think what I will do is I will just have that marked before we forget. Yes, all right.

MR. YOUNG: Are we all set, Mr. Commissioner?

THE COMMISSIONER: Yes.

MR. YOUNG: Q It appears to state, "Patient ordered digoxin to be given ... ", is that what "PT" means, patient?





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A. Patient, yes.

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Q. "Patient ordered digoxin to be  
given BID ... ",

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what is "BID"?

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A. Twice a day.

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Q. Then it says,

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"Given at 5:30 for dig. level and  
signed off on medication sheet by  
night nurse."

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A. Yes.

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Q. "Per diem staff did not receive  
adequate report regarding the early  
administration of digoxin and went  
by the nursing care plan, reporting  
the 900 digoxin",

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and in brackets it says ---

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THE COMMISSIONER: Repeating, I think.

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MR. YOUNG: I am sorry?

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THE COMMISSIONER: I think repeating  
is more likely.

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MR. YOUNG: I am following my friend's  
suggestion. She is getting me in trouble.

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THE COMMISSIONER: Well, it could be  
either, but I think repeating sounds a little better.

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MR. YOUNG: Q. Then in brackets it says,

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"The med ticket had been moved to  
2100 slot by night nurse and mentioned  
in report that patient was for digoxin  
level today",

and it is signed by, is that Elizabeth Radojewski?

A. Yes.

Q. Can you tell me, would this be  
one of those four incidents that we discussed  
yesterday, do you have any idea?

MS. THOMSON: Excuse me, Mr.  
Commissioner, could I just at this stage ask Mr. Young  
to make note of the date of that incident, please?

MR. YOUNG: Sure. The incident date  
appears to be the 24th day of the 9th month, 1980.

MS. CRONK: September.

MR. YOUNG: September.

THE COMMISSIONER: It was made on the  
24th and it is made at, the incident time is 9 o'clock  
in the morning, but the report is made at some time  
that I cannot read.

THE WITNESS: It would almost look like  
1800 to me.

THE COMMISSIONER: Would it be 1800?  
It might well be.

MR. YOUNG: On the 24th of September.





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THE COMMISSIONER: And the baby died at 4 o'clock the next morning. Yes, all right.

MR. YOUNG: Well, perhaps Ms. Radojewski will be able to help us with that when she gives evidence.

THE COMMISSIONER: Yes, all right.

MR. YOUNG: Q. Do you know if this was one of the children that we discussed yesterday, one of the four children?

MS. KITELY: Mr. Commissioner, if I might rise, I think my friend is referring to Exhibit 300 and the entry is for the 17th of November with reference to the three errors.

THE COMMISSIONER: What page is that on?

MS. KITELY: I am sorry, sir, mine does not have page numbers.

MS. FORSTER: It is page 64, Mr. Commissioner.

MS. KITELY: If that is what my friend is referring to.

THE COMMISSIONER: Well, yes, but the entry is for September, that is, the incident report is for September and this meeting is in November, but the meeting in November could of course have referred back.







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MS. CRONK: Ms. Kitley is quite correct, sir. Indeed, that was the evidence I led in chief through ms. Browne. If you turn to the very next page, the dates of the four medication errors that are discussed at that meeting are set out; three took place in October, one in November, which is why I suspect that Ms. Thomson before I could get on my feet suggested that the date of the Gage incident be read out.

THE COMMISSIONER: I am sorry, the next page is page 65?

MS. CRONK: No, page 64, sir, the second full paragraph starts with the words, "Digoxin errors ... ", you will see the numbers beside it.

THE COMMISSIONER: Oh, I see.

MS. CRONK: Three in October, one in November.

THE COMMISSIONER: I see. Yes, all right.

MS. KITLEY: Thank you.

MR. YOUNG: Q. Thank you. Now, this was another incident, it appears, where there was a per diem nurse involved; am I correct?

A. Yes.

Q. When such an error occurred,





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whether it be a per diem nurse or some sort of student nurse involved or a registered nurse who is on full-time duty on a regular team, would there be any sort of monitoring program, a program whereby the activities of an individual, the nurse, could be closely supervised in the future? Do you know of anything like that? I mean, what happened -- let me just finish and then I will let you answer.

What would happen if the same nurse was involved in a number of medication errors? Is there any sort of program that you are familiar with whereby the Hospital or one of the other individuals on the ward could monitor that nurse's activities a little closer?

A. I think the situation is different for the different types of nurses that you mentioned.

Q. All right, let us go one by one then. Let us start with a per diem nurse.

A. If it was a per diem nurse, that per diem nurse is assigned from nursing office to cover in a ward area where there is a shortage, and indeed, that would go on her record in nursing office. If indeed there were repeated incidents, there certainly would be question about whether





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indeed she should be giving medication.

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Q. How about the registered nurse, a registered nurse who is a member of a team who comes in three times a week or however many times she is called upon?

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A. If indeed there were repeated problems around medication, that would become the responsibility of the head nurse and the teaching team leader to look at why that was happening.

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Q. There is no formalized program, then, it is just the way that team leader or the head nurse wanted to approach it?

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A. That is correct.

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Q. Do you know if any of the nurses on Wards 4A or 4B during the period we are interested in or just prior to the period were being monitored or watched or assisted in that way?

A. Not to my knowledge.

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Q. Now, yesterday you were also asked whether or not you recall any nurses coming to you complaining about the activities or the conduct or behaviour of other nurses and you told us you did not.

A. That is correct, yes.

Q. Would it assist you at all if I





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suggested that Nurse Parcels -- I am probably  
pronouncing that wrong -- Nurse Parcels and Nurse  
Mary Cooney actually approached you complaining  
about the behaviour of Phyllis Trayner surrounding  
Baby McKeil?

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A. I do not remember that.

7

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Q. You have no recollection of that  
at all?

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A. No.

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THE COMMISSIONER: I am sorry, Nurse  
Parcels and Nurse?

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12

MR. YOUNG: Nurse Cooney, Mary Cooney.

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THE COMMISSIONER: Cooney?

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MR. YOUNG: Cooney, C-o-o-n-e-y.

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MR. OLAH: Do you have the reference  
for that, Mr. Young?

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MR. YOUNG: I wish we did. That is  
information they gave to the police and I assume  
information they will give in this Commission.

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THE COMMISSIONER: Yes, but it was  
re which baby?

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MR. YOUNG: Baby McKeil, Mr. Commissioner.

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THE COMMISSIONER: All right. I am  
not accepting this as evidence, of course, everybody  
will understand. I am merely making a note of it so







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that I will understand it if it comes up again, but  
it clearly is not evidence even in a Commission it  
is not evidence.

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MR. YOUNG: No, I am not suggesting  
that it would be. I am simply asking the witness  
whether or not that helps her remember.

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Q. We also discussed yesterday a  
number of meetings that occurred in the ward. There  
was another meeting at one of the nurse's homes.  
There is another meeting I think that occurred over  
that period, and I think that was on March the 20th  
in the Hospital. I believe you were in attendance.  
Does that ring a bell?

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A. March the 20th?

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Q. Yes.

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A. What day was that, please?

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Q. That would have been a Friday,  
I think, 1981. I think it was a new committee and  
they met for the first time, and you can correct me  
if I am wrong, I think it was entitled the  
Paediatric Care Committee; do you remember sitting  
on that committee?

A. I do not remember, no.

MR. YOUNG: Mr. Commissioner, Exhibit  
183 are the notes of Ms. Lund. I am going to be





H.15

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referring to them. Perhaps the witness could be  
shown a copy.

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THE WITNESS: Thank you.

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MR. YOUNG: Q. I am referring to the  
bottom of the second page of that exhibit. The way  
I read it, it says:

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"NB: Friday, March 20th, 1981 ... "  
obviously the author thought it was very important,

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10

" ... I had the first meeting of the  
Paediatric Care Committee ... ".

11

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A. Could I correct it, it is  
Palliative Care Committee.

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Q. Well, that would explain one  
reason that you might not have remembered. Does that  
help your recollection?

15

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A. Yes, I did sit on that committee.

17

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Q. All right, that is my error.  
Just to read on, it is a very short passage, "Carol  
... " help me with your name?

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A. Putherbough.

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Q. Thank you.

" ... was in attendance and she  
spoke about the trying time the staff  
on 4A/B was going through due to the  
number of deaths. There was concern





H.16

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"that they could have saved ... "

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A. Could not.

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Q. What do you read that as, not

have saved?

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I/BM/ak

THE COMMISSIONER: "Could not save".

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MR. YOUNG: Q. "Could not save any

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of those children".

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Now that you remember attending that meeting could you tell us who else was there?

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A. There was a quite a large group. The chaplin was there, there was representation --

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Q. The chaplin was there?

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A. Yes.

11

Q. Yes.

12

A. There was representation from social work, the clinical specialist who worked in the Hematology/Oncology Ward sat on that Committee as well, there was a head nurse represented.

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Q. Who was that?

16

A. Carol Shepperd, who worked on

17

6C. I think there were other people on that

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Committee, I'm sorry, I can't recall them all.

19

Q. There were other people in

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the room?

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A. There was a large table with a number of people.

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Q. All right. Do you remember who invited you to sit on that Committee?

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Browne, cr.ex.  
(Young)

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A. I believe it was Marie Lund who had organized that.

Q. And what did she tell you the purpose of this particular meeting would be?

A. It was to discuss the care of children and families around the issue of death and dying and to look at from a hospital standpoint how you deal with that issue. The reason I felt I was invited was to look at what support measures were needed for the families and the staff.

Q. It is interesting that the meeting happened on March 20th, 1981, because there were significant events that weekend, as we both know.

A. Yes.

Q. Do you know why the meeting was held on that date?

A. I know it had been discussed for quite some time before that there had been movement in other hospitals towards setting up a palliative care unit that would deal specifically with dying children. So, it had been in the wind for a long time. I'm not sure why that particular date but because of the number of people involved it had been planned some time in advance.





Browne, cr.ex.  
(Young)

I.3

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Q. All right. And at the meeting do you recall any solutions being put forth suggested by any of the members?

A. I don't believe solutions. I think there were delegated tasks from the people on that Committee to look at what was going on at other hospitals, to bring forth some suggestions as to how the Committee might move forward and we did continue to meet for about a year.

Q. When was the next meeting, do you recall?

A. No.

Q. Was it a year later, was it a month later?

A. I think it was several months later.

Q. Were any of these solutions ever implemented or suggestions? People went and looked and investigated at what was going on at other hospitals.

A. Yes.

Q. I take it they came back and reported?

A. Yes.

Q. Yes. And were changes made





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as a result of their reports?

A. I can't remember specific changes. There was discussion about whether indeed we set up a unit and that was decided against. There was a discussion about having a team of staff who could go in and work with staff around that issue in particular ward areas.

Q. Let's move on to another meeting that I believe you attended related to the cause of death of some of these children. I don't believe that has been discussed yet. That occurred on Monday, March 23rd at Nurse Radojewski's house.

MR. BROWN: Well, that hasn't been discussed yet, at least, it has not been discussed here deliberately and it should be more properly be brought in in the second phase than the first phase.

THE COMMISSIONER: Yes. Well, it might well be. Are you going to ask something about the cause of death?

MR. YOUNG: Oh, I am, Mr. Commissioner. I will be honest with you. I think there was a great deal concerning the cause of death discussed at that meeting, and I think if you hear me out you will agree. For instance, the care of Baby Pacsai was discussed at that meeting, the behaviour of some





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3 of the nurses was discussed at that meeting. I  
4 think it is of great relevance.

5 THE COMMISSIONER: Well, Mr. Brown,  
6 we can do nothing but let him proceed and you can  
7 take objection as you like. But bear this in mind  
8 if there is only a small part of it that is excluded  
9 I would much rather have it dealt with now than call  
10 her back. But I agree that the rules are that we  
11 don't deal with the second issue. But you say that  
12 it is the first issue that you are dealing with?

13 MR. YOUNG: Yes, Mr. Commissioner.

14 THE COMMISSIONER: All right.

15 MR. YOUNG: I agree with you, and  
16 in fact as you have suggested, this is a meeting  
17 where there was discussion on both questions that  
18 we are looking at but most of the discussion appears  
19 to me to have centred around the first question that  
20 we are looking into right now.

21 MS. KITELY: Might I say for the  
22 record, sir, that I support Mr. Brown's position,  
23 his objection to going into this meeting.

24 THE COMMISSIONER: Well, the only  
25 reason I would not support his position would be  
if there is just a little that has to do with the  
second issue. We don't want to have to call







I.6

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3 Mrs. Browne back, that's all, just for that, for  
4 some small thing that we can deal with it. Do you  
5 have any comment?

6 MS. CRONK: Yes, sir. I am relieved  
7 to say that this was a matter of some consideration  
8 by Commission Counsel before Ms. Browne commenced  
9 her evidence. It was our view then and now that  
10 in the main the record of what occurred that evening  
11 goes to the second phase of this Commission's Inquiry  
12 not to the first. I should point out if there is  
13 any concern on the part of my friend Mr. Young as  
14 well that the only documentary evidence before you  
15 concerning that meeting to date are a series of  
16 notes taken by Elizabeth Radojewski, or at least  
17 that is what the evidence suggests to date that  
18 include that meeting amongst many others. There  
19 were a number of people in attendance at the  
20 meeting, several of whom will be called as witnesses  
21 before you.

22 So, should he have any concern it is  
23 not solely through this witness that evidence might  
24 be led concerning the events of that evening and  
25 that meeting. But the view of Commission Counsel  
is that that meeting should properly be dealt with  
in Phase 2 of the Inquiry.





I.7

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THE COMMISSIONER: Yes. Well, I  
have to let Mr. Young continue.

MS. CRONK: I recognize that, sir.

THE COMMISSIONER: Because I don't  
know what he is going to ask.

MR. YOUNG: Thank you, Mr. Commissioner.

THE COMMISSIONER: But you have  
been warned.

MR. YOUNG: Yes, so I notice.

THE COMMISSIONER: That there are  
people ready to pounce.

MR. YOUNG: That is not news,  
Mr. Commissioner.

Q. Did you attend at this meeting?

A. Yes.

Q. Yes.

A. Could I say that I left half  
way through the meeting.

Q. Sure, you can say that.

A. The meeting commenced I believe  
about 7:00 and I left between 8:00 and 8:30.

Q. So, you may not be able to  
help us as to what happened in the latter stages of  
the meeting. Who invited you to this meeting?

A. Elizabeth Radojewski.





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Q. Yes. Did she tell you what  
the purpose of the meeting was?

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A. To deal with staff concerns  
at that point in time, with what had happened on  
the ward over the weekend.

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Q. Yes. When did she invite you?

A. It was some time Monday.

Q. Did she telephone you?

A. No, she asked me when I was  
on the ward.

Q. Yes. Who else was at that  
meeting?

A. There were quite a few staff.  
If we can refer to Liz' notes, that would tell you  
more accurately. Janet Beed was at that meeting,  
Mary Costello was at that meeting.

Q. Well, let's refer to another  
set of notes. Was Mary Costello at that meeting?

A. Yes.

Q. Yes. Was she taking notes  
during the meeting?

A. I don't recall that she did.

MR. YOUNG: Well, Mr. Commissioner,  
in the same way that we have made exhibits out of  
Ms. Lund's notes and Ms. Radojewski's notes, I am





1  
2 offering another set of notes, Mary Costello's notes.  
3 I know that we will be hearing from that individual  
4 but once again I think there are some very relevant  
5 portions of this document that I would like to put  
6 to this witness.

7 THE COMMISSIONER: Yes, all right.  
8 Yes. Yes, you object to that?

9 MS. KITELY: Yes, I do, sir.  
10 One of our clients is Mary Costello and while her  
11 handwriting appears in the books and while my  
12 friend might think he is a handwriting expert and  
13 compare the two, I don't know that the Commission  
14 can assume that they are all Mary Costello's hand-  
writing.

15 MR. YOUNG: No, I will tell you  
16 what it is. It was Mary Costello who said this  
17 at the preliminary hearing that she prepared these  
notes.

18 MS. KITELY: Well, shouldn't my  
19 friend be directing these questions to Mary Costello?

20 MR. YOUNG: Well, I have already  
21 gone through that, Mr. Commissioner, I am in your  
22 hands.

23 THE COMMISSIONER: Well, there is  
24 no question that it would be more valuable but surely  
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3 while we have Mrs. Browne here, should we not - if  
4 there are questions, and I don't even know what they  
5 are, but there is nothing wrong with receiving the  
6 notes, is there, at this point?

7 MS. KITELY: Subject to proof that  
8 they are done by Mary Costello, sir.

9 THE COMMISSIONER: Well, the first  
10 question can be to her, are these your notes. Is  
11 she not planned as the next witness, or was to be  
12 the next witness?

13 MS. CRONK: Was planned as the  
14 next witness. What the order will be now, I don't  
15 know.

16 THE COMMISSIONER: Yes, but she  
17 is still in contemplation.

18 MS. CRONK: She has been invited  
19 to give evidence before the Commission.

20 THE COMMISSIONER: Yes.

21 MS. KITELY: Well, since my friend  
22 is offering Mary Costello's notes, so long as it is  
23 clear that has to be subsequently proven to be  
24 Mary Costello's notes.

25 MR. YOUNG: It will be my submission,  
it is my submission that in the preliminary hearing,  
Volume 7, page 1774 ---





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THE COMMISSIONER: She identified  
them?

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MR. YOUNG: She did so. They weren't  
made an exhibit. My understanding is that they  
weren't made an exhibit in that proceeding,  
Mr. Commissioner. They had slightly different  
rules of evidence than we do.

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THE COMMISSIONER: I would hope so.  
MR. YOUNG: So do I. But yet she  
did say that she wrote the notes. Actually, I  
believe that she said towards the end of page 1774  
she states that she made the notes in early April,  
1981.

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THE COMMISSIONER: Yes, all right.  
Well, what number is this then, 309, is it?

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THE REGISTRAR: 309.  
THE COMMISSIONER: 309.  
---EXHIBIT NO. 309: Notes prepared by Mary  
Costello.

MR. YOUNG: Mr. Commissioner, as  
you will note, these particular notes refer to  
quite a number of things that we have discussed or  
likely will discuss. Right now I draw your attention  
to page 4, the last page. Approximately half way





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3 down the page, Ms. Browne, I think you will see an  
4 entry, it begins "Monday evening meeting at Liz's  
5 home".

6 THE COMMISSIONER: Yes.

7 MR. YOUNG: Q. Yes. It goes on  
8 to say:

9 "To support staff, let them express  
10 fears and worries and support one  
11 another. Attended..."

12 And then she gives a list of the individuals present.

13 MR. BROWN: Where are we?

14 MR. YOUNG: I'm sorry, fourth  
15 page, half way down the page, just over half way.

16 Q. She says that Diane Croswell  
17 got there late, that you were there, Janet Beed  
18 was there, Bertha Bell was there, Karen Power was  
19 there, Angela...

20 A. Basciano.

21 Q. Right. You can help me with  
22 the next one too, please, Leslie Presnail.

23 A. Presnail, yes.

24 Q. Meredith Frise was there,  
25 Mary Jean Halpenny.

A. Yes.

Q. Liz, Mary Mandal, Susan Nelles





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3 was there, Phyllis Trayner was there and then it  
4 says in brackets (plus?), so, I guess there might  
5 have been more people there that she didn't record?

6 A. Yes.

7 Q. "And me", that is how it reads.

8 A. Yes.

9 Q. Then it goes on to say that:

10 "All expressed fears, worries,  
11 questions. In retrospect remember  
12 Susan saying I've got my private legal  
13 counsel from lawyer room-mate. I know  
14 I didn't do anything wrong. I know  
15 I measured dig. ..."

16 And above that it says Pacsai.

17 "...correctly. I remember small  
18 amount in syringe, plunger not far  
19 out, I squirt, checking with Mary  
20 Jean, giving Kevin Pacsai..."

21 Does that say last rite.

22 "Card, right baby."

23 And then it goes on to say:

24 "We will get through this, must stick  
25 together and support each other.",  
and that is the end of quote, that was a statement  
allegedly made by Ms. Nelles.







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And then the notes go on to say:

"After meeting my concern re Karen Power's anger (unresolved) toward Hospital for Sick Children and investigation."

Do you recall any of that discussion taking place?

A. I recall a discussion around fears and worries.

Q. About what?

A. Fears and worries.

Q. Yes, I know, but about what, what were you worried about?

A. The nurses expressed worries about what was happening on the ward.

Q. What was happening on the ward?

A. Well, just the fact of the changes in nursing policy over that weekend and that dig. had been locked up and they felt there was questioning of nursing practice at that time.

Q. Is there any details that you recall about how the nursing practice was being questioned?

A. No. Part of their concern centred around the fact that digoxin had been locked





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2 up and indeed a nursing supervisor was on the ward  
3 24 hours a day, which was quite unusual. So, they  
4 were feeling that they were being watched and  
5 questioned about what they were doing.

6 Q. Yes. Do you remember Baby  
7 Pacsai being discussed?

8 A. No.

9 Q. You don't, maybe you weren't  
10 there then?

11 A. I may not have been.

12 Q. Do you remember Susan Nelles  
13 talking about her legal counsel?

14 A. No.

15 Q. You don't, maybe you weren't  
16 there for that part either? This was the  
17 Monday evening, was it not?

18 THE COMMISSIONER: Yes, Mr. Brown.

19 MR. BROWN: At this point I am  
20 simply going to submit at this point and put you  
21 on notice that I am going to request the right to  
22 cross-examine the witness on this. This matter  
23 has been gone through ad nauseam.

24 THE COMMISSIONER: Well, remember  
25 that she hasn't said anything about - the only thing





1  
2 that she has done here --

3 MR. BROWN: Well, counsel for the  
4 police has put in a four-page document. The witness  
5 seems to have very limited knowledge of anything in  
6 the document. With respect, I find the tender of  
7 documents on that basis scandalous. Nonetheless --

8 THE COMMISSIONER: Well, I wouldn't  
9 get too worked up about it, Mr. Brown. Obviously  
10 this is a document that is probably going to be  
11 referred to by Nurse Costello.

12 MR. BROWN: Well then, why not let  
13 most of it go in through Nurse Costello. Nonetheless,  
14 I simply make the submission that I will be asking  
15 for the right of cross-examination. He has read  
16 a statement attributed to my client. This matter  
17 has been gone into at great length at the Preliminary  
18 Inquiry and I would like to cross-examine the witness  
19 on it at a later time.

20 MR. YOUNG: May I proceed,  
21 Mr. Commissioner?

22 THE COMMISSIONER: Pardon?

23 MR. YOUNG: May I proceed,  
24 Mr. Commissioner?

25 THE COMMISSIONER: Yes, yes, you  
can proceed. You have given me warning of that.





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3 I am not committing myself. You have to tell me  
4 that you somehow -- so far all the witness has said  
5 is that I wasn't there when Susan Nelles made --

6 MR. BROWN: Well, fine, but before --

7 THE COMMISSIONER: Are you worried  
8 that there might be something in the --

9 MR. BROWN: I am simply worried about  
10 the procedure. Mr. Young puts a statement attributed  
11 to Susan Nelles to the witness before the witness  
12 is even asked the question whether she heard Susan  
13 Nelles say anything.

14 THE COMMISSIONER: I'm not going to  
15 argue with you on the question. If you think that  
16 your client has been harmed in some way you can  
17 cross-examine. I don't see any harm to her at all.

18 MR. BROWN: But the statement was  
19 made in context. For some reason Mr. Young has  
20 felt fit to trot this old chestnut out again and  
21 I think it should be dealt with again at this time.  
22 I think that the only reason this particular thing  
23 was put to him, he could have asked first whether  
24 she heard Susan Nelles say anything with respect to  
25 Kevin Pacsai and if she said no then that would have  
been the end of the matter.

MR. YOUNG: It is really a moot







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issue, she did say no.

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THE COMMISSIONER: All right. Well,

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I think I would just carry on, Mr. Young.

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MR. YOUNG: Thank you, Mr. Commissioner.

Q. On page 3 of the same document, Ms. Browne, I refer you once again a little more than half way down the page, this is again dealing with the death of Baby Pacsai.

THE COMMISSIONER: A third of the way down did you say?

MR. YOUNG: Two-thirds, Mr. Commissioner.

THE COMMISSIONER: Oh, yes.

MR. YOUNG: Q. It begins:

"I asked Lynn Johnson this a week later. Kevin Pacsai transferred from McMaster Hospital March 11 ?

"About 1500 just as I went into interdisciplinary meeting admitted by George Meredith - help, I asked Diane to help because team leader ... "

TL I imagine is team leader, is it?

A. Yes.

Q. " ... is busy and at meeting later - new baby."

I am sorry.

THE COMMISSIONER: "Saw baby", isn't it?

MR. YOUNG: "Saw baby", thank you.

Q. "No acute distress process ... ",





J.2

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can you help me with the next word, please?

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Then she goes on to say:

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Who is Mike Schaffer?

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Fellows.

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" ... processed orders and life and left Sue Nelles relieving on 4B, long night. Given Pacsai among others because RN in 31 wanted RN to keep an eye on babies. Susan experienced, competent, happy to have her as relief.

"Next morning heard that Kevin had arrested, resuscitated, sent to ICU where he died later in a.m. Worried whether parents had been notified and changing condition - transfer."

"Did not worry about quality of care.

Later after death, Mike Schaffer ... "

A. He is one of the cardiology

Q. Thank you.

" ... told me about ... ",  
and I can't make out the next few lines, the next few letters.

MS. CRONK: Elevated potassium.

MR. YOUNG: Q. " ... elevated potassium





J.3

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"and asked if he could have got some.

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I thought no, trusted all the nurses"

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THE COMMISSIONER: " ... re their

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care and capability."

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I would like to know what the question is before we  
have another outburst from Mr. Brown, what questions  
you are going to ask?

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MR. BROWN: With respect, Mr.

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Commissioner, these are not her notes.

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THE COMMISSIONER: I am doing your work

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for you now so you don't - what is the question you  
are going to ask?

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MR. YOUNG: I am interested in whether  
or not this witness can add to anything contained in  
the notes?

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THE COMMISSIONER: Are these notes of

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a meeting?

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MR. YOUNG: Of a meeting that

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occurred Monday, March 23rd, 1981 at Liz Radojewski's  
house.

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MS. KITELY: With all due respect,

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sir, they are clearly not, because it starts off with  
" ... interview - ... ".

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THE COMMISSIONER: I agree that it is

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not as apparent as Mr. Young, is this something that

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J.4

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was said, do you remember any of this taking place  
at the meeting?

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THE WITNESS: No.

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THE COMMISSIONER: Isn't that just the  
end of that?

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MR. YOUNG: That is fine, those are  
my questions.

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MR. BROWN: That wasn't the question,  
Mr. Young went through and read at great length things  
which this witness had no knowledge of. I suggest  
the question be put forth regarding the witness'  
personal knowledge of the matters in general and  
then asked --

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THE COMMISSIONER: It would have been  
faster, yes, all right. Now, Mr. Olah, you have  
something; I am sorry, Miss Kately?

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MS. KATELY: I was going to ask whether  
my friend intends to continue doing this?

THE COMMISSIONER: Well --

MS. KATELY: For one thing, I think  
the witness should have an opportunity to read the  
entire document so she knows where she is coming from.

THE COMMISSIONER: Yes, all right.

MS. KATELY: And secondly, I support  
Mr. Brown's position.

THE COMMISSIONER: Yes.





J.5

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Now, Mr. Olah?

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MR. OLAH: In all fairness, Mr.

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Commissioner, for everyone concerned, the notes with

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respect to the meeting of the 23rd start at the last

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page half way down, and to suggest that the notes on

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page 3 relate to the meeting of March 23rd is just

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not so. So if my friend is suggesting that these

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were said during a meeting that is not reflected even  
by the document let alone by the witness' evidence.

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THE COMMISSIONER: The witness seems

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to have confirmed what you have said.

12

MR. YOUNG: I thought we had cleared

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that up, I will try to move on.

14

THE COMMISSIONER: Now, are you going

to ask any more questions about this?

15

MR. YOUNG: I have one more area to

16

cover Mr. Commissioner.

17

THE COMMISSIONER: Oh, tell me what

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they are, tell me what it is before we ask the question?

19

MR. YOUNG: Well, this particular

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witness was involved in, and in effect has spent much

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of the last few days telling us about stress on the

ward.

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THE COMMISSIONER: Yes.

23

MR. YOUNG: And in particular she

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J.6

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talked about Susan Nelles and Phyllis Trayner. I

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think you will find on page 2 of these notes some

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discussion of that. I wondered if it might help

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the witness refresh her memory, there is some very

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specific mention of action and reaction that was

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going on in the ward.

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THE COMMISSIONER: These are Miss  
Costello's notes?

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MR. YOUNG: They are Mary Costello's  
notes.

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THE COMMISSIONER: Where is this on  
page 2?

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13

MR. YOUNG: Now I am about half way  
down page 2.

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THE COMMISSIONER: Let us all read it  
silently and you can tell us what it is we have to  
do, what page?

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MR. YOUNG: Page 2. I would start  
where it says: "Some interpersonal problems ...",  
and I am not going to read any more now.

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THE COMMISSIONER: All right, we have  
to find it.

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MR. YOUNG: And they go until about  
one-third of the way down page 3, Mr. Commissioner.

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THE COMMISSIONER: Yes, all right. What





J.7

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2 is the question going to be?

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4 MR. YOUNG: Let me preface the question  
5 because my friends have some concerns. I have spent  
6 the last two and a half days listening to all sorts  
7 of evidence about stress; and all sorts of evidence  
8 about the nurses' behaviour and complaints.

7

8 What I was going to ask the witness  
9 is whether or not she recalls, and I am going to go  
10 into some of the incidents discussed here. I thought  
11 because of her position that this is information  
12 that would likely come to her attention. I am in  
13 your hands, Mr. Commissioner.

12

13 THE COMMISSIONER: I don't see any  
14 objection to some specific reference to a specific  
15 incident if she has any recollection. Does anyone  
16 have any objection to that? Well, all right. Yes,  
17 Miss Kitley?

17

18 MS. KITELY: May I say, sir, I don't  
19 object to my friend asking about specific incidents,  
20 but the way in which he has done it so far we still  
21 have parts of it read and then a question asked.  
22 Rather than doing it that way can I suggest that he  
23 ask about an incident and if he doesn't get an  
24 answer then perhaps there can be reference to the  
25 notes?

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J.8

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THE COMMISSIONER: The notes are made  
by somebody else.

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MS. KITELY: Exactly.

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THE COMMISSIONER: I think Miss Kitley  
is right, Mr. Young, the proper way to do it is:  
"Are you aware of X and Y and Z and if you are that  
is fine, if you are not that is fine as well?" But  
this obviously is evidence that he intends to go over  
when Miss Costello is giving evidence, so there is  
nothing, it is obviously something that we are going  
to have to deal with at some time and this witness  
may help us and may not. You just put your questions  
in that form.

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MR. YOUNG: Thank you, Mr. Commissioner.

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THE COMMISSIONER: And I think  
probably the witness having read the document, that  
is good enough for the moment and you can just simply  
say, do you remember an incident, or do you remember  
these facts?

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MR. YOUNG: Yes, thank you, Mr.  
Commissioner.

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Q. Are you aware, Ms. Browne, of  
an incident involving Dr. Freedom, where he reassured  
Nurse Trayner that it wasn't her fault, or perhaps  
that it was her fault, there is some confusion in the





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notes, does that ring a bell?

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A. I recall his reassuring her that  
it was not her fault.

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Q. What baby are we talking about  
now?

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A. I remember that in reviewing  
the babies in August when Dr. Freedom was on service.

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Q. Can you help me with the name  
of the baby, or are we talking about a group of  
babies?

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A. We are talking about a group,  
from my knowledge it was a group and they were looking  
and questioning what had gone on.

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THE COMMISSIONER: This would be the  
group, the July group, I take it?

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THE WITNESS: Yes.

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MR. YOUNG: Q. And what is it you  
recall, did you speak to Phyllis Trayner about this?

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A. No. I recall being in on part  
of that discussion between Dr. Freedom and members  
of Phyllis Trayner's team.

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Q. And what did he say?

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A. He indeed was explaining  
anatomically what was wrong with the children; why  
they were in the difficulty they were; and why they

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did not respond to their resuscitation efforts.

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Q. Did you hear at any time that  
Dr. Freedom blamed Phyllis Trayner for these deaths?

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A. No.

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Q. And I think you have told us  
that you can't help us with complaints brought to  
you. Let me rephrase that. You don't know of any  
complaints with respect to Phyllis Trayner's  
behaviour around the arrest, do you?

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A. Only as I have stated earlier,  
discussion with Miss Radojewski, but it wasn't things  
that were brought directly to my attention.

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Q. Were you aware that some of the  
other nurses felt a little uncomfortable as a result  
of Phyllis Trayner's behaviour?

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A. I was aware of the feeling, yes.

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Q. And how did you become aware of  
that?

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A. Again, I think primarily in  
discussion with Mary and Liz about the workings of  
the teams.

Q. Mary?

A. Costello.

Q. Can you help me any further, what  
did they tell you?





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A. There was some concerns raised in terms of how we support members of the nursing staff around there, their stress and their concerns about what was going on.

Q. I suspect some of my friends may have questions or comments to you about this document, but I am going to leave it for the time being.

I have one final question for you, Ms. Browne. With your present state of knowledge of whatever that may be, do you believe that it is possible, and I stress possible, that some of the babies were murdered through a deliberate administration of digoxin?

MS. KITELY: Might I rise?

THE COMMISSIONER: I think I would prefer the question would be "suffered from a massive overdose of digoxin".

MR. YOUNG: This is all right.

THE COMMISSIONER: Administered by --

MR. YOUNG: This is our old chestnut.

THE COMMISSIONER: Pardon?

MR. YOUNG: This is our old chestnut.

THE COMMISSIONER: It doesn't matter.

MR. YOUNG: I am not going to quarrel.







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THE COMMISSIONER: It is only, I am not prohibited, I don't know, anyone else can use any term they like, but I am not going to use that vulgar word. Now, what is your problem, Miss Kately?

MS. KATELY: I wasn't rising on the semantics, sir.

THE COMMISSIONER: Yes.

MS. KATELY: I was rising on the question itself. We have not established that this nurse's position decided how a patient died or from what cause, and unless there is evidence to that effect in my submission she ought not to be asked. I make this point at this point in time because if my friend intends to do this with every nurse we will be repeating it again and again. We have heard the evidence from the medical staff and from God knows how many other people over the last six months, and in my submission it is not appropriate to put the question to this witness whatever the semantics.

THE COMMISSIONER: Does anyone else support that position? I don't see anything wrong with the question, you can ask the question. I can tell you though I am not going to pay a great deal of attention to it unless she gives me her reasons. If she goes in for some psychic considerations one

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way or the other I can, certainly I can rise above that.

MR. YOUNG: I have no doubt about that, Mr. Commissioner.

THE COMMISSIONER: Yes. All right. Did you say you wanted to say something, it looks as though you wanted to say something?

MR. YOUNG: Mr. Brown always looks that way when I am cross-examining.

MR. BROWN: I can support what Ms. Kitley said, we can ask anyone in the room the same question and it is the same --

THE COMMISSIONER: You know, strangely enough I am perfectly entitled to go and ask anybody in the room. I won't do it I promise you, but there is nothing that prevents a commissioner from doing that very thing. I can go out to a cocktail party tonight and ask people around, and I can assure you that is something I don't do, although they keep asking me. This is the trouble with commissions, you can ask questions like this, it is an inquiry, it is not a trial. We have been asking I am afraid every doctor that has been here just that question; what is your view now? The doctors' opinions are somewhat more valuable, not a great deal, but more valuable





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than Mrs. Browne. Mrs. Browne's opinions are more  
valuable than other people in the room but it is a  
question of weight surely, isn't it?

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MR. BROWN: Well, essentially it is a question of weight, but may I make the submission if he wants to ask her about the cause of death, he can certainly ask her that, although with respect to many of the children she probably has very little information.

MR. YOUNG: Well, let us hear that from her.

MR. BROWN: Would you please let me finish my submission?

MR. YOUNG: I do not want you giving evidence for the witness, Mr. Brown.

MR. BROWN: I am not.

THE COMMISSIONER: Well, just one, please. Even in a Commission it is customary to address the Commissioner. So, all right, go ahead.

MR. BROWN: So certainly questions on that are relevant and then their weight will depend upon the knowledge of the witness. The phraseology of the question I think is another point.

Mr. Commissioner, in your ruling you yourself have said that you do not have the authority to make any finding with respect to the state of mind of any person or persons. If that indeed be







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2 the case, I would argue on the basis of the Bortolotti  
3 case that if you do not have the authority to do  
4 that, then the evidence in relation to that is not  
5 relevant nor is it admissible.

6 THE COMMISSIONER: Yes, but you  
7 and I know that there is a special legal meaning  
8 of murder, but a layman does not. He thinks that  
9 everybody who kills everybody with some form of  
10 deliberation is therefore a murderer. We know that  
11 that is not so, at least I know that that is not so.  
12 I do not know whether you know that, but I do.

13 So that is the problem, and he is  
14 using a popular term. I would prefer that you  
15 asked whether the children died, whether in your  
16 opinion the children died from digoxin intoxication,  
17 and if so, if you have any thoughts on the question  
18 of whether the digoxin was administered accidentally  
19 or not. Now, that is what I would prefer, but you  
20 go ahead and do it whatever way you want.

21 MR. YOUNG: Mr. Commissioner, we  
22 are fast approaching 1984, and I am trying to purge  
23 the word "murder" from my language, again to some  
24 sort of double speak but have not quite succeeded.

25 Q. Let me rephrase the question,  
Ms. Browne. With your present state of knowledge or





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3 whatever that may be, do you believe that it is  
4 possible, and again I stress possible, that some  
5 of the babies died as a result of a deliberate  
6 overdose of digoxin?

7 A. It is possible.

8 Q. Can you help us ---

9 MR. SHANAHAN: Sorry, I did not  
10 hear that answer?

11 THE COMMISSIONER: She said yes,  
12 it is possible.

13 THE WITNESS: It is possible.

14 MR. YOUNG: Q. Now, the Commissioner  
15 promised me he would give more weight to your  
16 answer if you could help us with the reason that  
17 you believe that, and can you? Why do you feel  
18 that that is possible?

19 A. If indeed digoxin levels  
20 were elevated beyond a reasonable level, then my  
21 question is why were they, how could they be, and  
22 if that is the case, then is it accidental, is it  
23 purposeful.

24 Q. But my question to you was a  
25 deliberate overdose, and you said that is possible.  
Do you have any reason to believe that it is unlikely  
that all of these administrations would have been





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accidental?

THE COMMISSIONER: Well, there are a couple of negatives in there. I am not too sure how you can answer that question.

MR. YOUNG: Q. All right, I will try again. Do you think that there is a possibility that this administration might have been intentional?

A. That is possible.

MR. YOUNG: I think I will leave it at that. Thank you very much.

THE COMMISSIONER: All right, thank you. Now, Mr. Brown, you said you wanted to further cross-examine. I do not know why, but if you want it you can have it right now.

MR. BROWN: Well, I do not want to right now. I think the practice was with Dr. Fowler to wait until the end.

THE COMMISSIONER: I do not think so. It seems to me Mr. Sopinka could not wait to get at him.

MR. BROWN: That was because I think of some further meeting that he had.

THE COMMISSIONER: Well, we will give you an opportunity this afternoon, but let me just add that I do not think that there has been





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anything said that concerns me. It may concern other people reporting on this matter, but it does not concern me. If you want to cross examine, I will give you an opportunity afterwards. You sit down now.

Who comes next? Ms. Thomson, do you come next?

MS. THOMSON: Yes, Mr. Commissioner.

THE COMMISSIONER: Yes, all right.

CROSS-EXAMINATION BY MS. THOMSON:

Q. Ms. Browne, my name is Thomson and I represent the Hospital for Sick Children.

I wonder if I could just take you back to your examination yesterday morning by Ms. Cronk, and particularly, I would like to get an understanding of the role of the ward meeting and communication books. As I understand it, when you were discussing these with Ms. Cronk, they stay on the wards?

A. Yes.

Q. Would I be right in saying that they are used as an inter-shift method of communication?

A. Yes.

Q. Frequently in a hospital where







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there are 12-hour shifts, members of various nursing teams will not come into direct contact with each other, and this is a method of getting messages, concerns, projected meetings across from one shift to another?

A. That is correct.

Q. Would those ward meeting books or communication books be observed by nursing administration?

A. Not to my knowledge.

Q. Not to your knowledge. I wonder if we could look, then, at the ward meeting book, and this is the last tab in Exhibit 300, Mr. Commissioner, and I am looking particularly at page 178 which is almost at the end. It is a November 11th, 1980 entry. I just draw your attention to the entry that is about a quarter way down on the left hand side of the page. I believe your attention was drawn to it yesterday, and it states:

"Our concerns will be taken to the area co-ordinator on a regular basis."

That would be the normal route of hierarchical communication?

A. Yes.

Q. Would I be wrong in implying





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from that entry that perhaps to that point the carrying on of concerns was done on an irregular basis, and certainly concerns raised in the ward communication book might not always be brought directly to the attention of the area co-ordinator?

A. It would appear that way, yes.

Q. Staying with Exhibit 300, could we go back, then, to page 5, which is at the very beginning of the book. I am referring particularly to the August 15th ward meeting, and if I am right, those present are Jane -- I am sorry, who would Jane be?

A. Jane Partridge.

Q. Jane Partidge. Phyllis would be Phyllis Trayner?

A. Yes.

Q. Susan Nelles and Liz Radojewski?

A. Yes.

THE COMMISSIONER: I am sorry, where ---

MS. CRONK: Page 6, sir.

MS. THOMSON: I am sorry, my apologies. You are quite right, it is page 6.

THE COMMISSIONER: Yes, all right.

MS. THOMSON: My notes are thus corrected.





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Q. Now, if we go down to I think  
it is the third item, we can see:

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"Psychiatrist for 4A/B: Dr. Wehrspann,  
will be meeting with him in September  
to set up some plans for 4A/B staff  
and patients."

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Now, I understand that these minutes, if we turn  
over to page 7, it would appear that the minutes  
were kept by Liz Radojewski; is that correct?

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A. Yes.

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Q. Now, as I understand it,  
Dr. Wehrspann did indeed become available to the  
patients and to the families in September of that  
year, I think that was your evidence yesterday?

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Q. I understand from Ms. Cronk's  
coments this morning that Liz' Radojewski will be  
called as a witness. Can you tell me if you know  
specifically if the concerns about having a staff  
psychiatrist were taken to the nursing hierarchy?

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A. I do not have that knowledge.

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Q. So I would be better to put  
that question to Ms. Radojewski?

A. Yes.

Q. Again, there is a second





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reference, this is January 8th of 1981 again in the communication book, and that, Mr. Commissioner, is found on page 29, again at the first tab. The reference was made there at the very bottom of the page:

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"We will talk with Andrea Fresin about the possibility of becoming involved with the wards on a long term basis to help us with our feelings about patient deaths."

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Carrying over on to the next page.

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Now, I understand from the entry at the beginning of that meeting you were present at that meeting; is that correct?

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A. Yes.

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Q. Do you know when indeed Andrea Fresin was contacted?

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THE COMMISSIONER: Is it Fresin ---

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THE WITNESS: It is Frewin.

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THE COMMISSIONER: Frewin, all right.

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F-r-e-w-i-n?

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A. That is correct.

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THE COMMISSIONER: What is her occupation?

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THE WITNESS: She is a mental health nurse who served as a consultant for nursing staff.

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THE COMMISSIONER: Was she on the staff of the Hospital for Sick Children?

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THE WITNESS: Yes. Could you ask your question again, please?

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MS. THOMSON: Q. Certainly. I am wondering if given that that entry is certainly done in a projected sense, that we will talk, can you tell me with any specificity as to when this woman was approached, and coming out of that meeting, by whom the understanding she was to be approached?

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A. My understanding, and I do not think it is in this particular reference, was that the decision was made that the team leaders would discuss whether indeed they wanted Andrea Frewin approached and for what purpose, and that that was delayed to their team leader meeting March the 10th. As far as my knowledge goes, it was discussed at the time. I do not <sup>know</sup> the outcome. To my knowledge, Andrea Frewin was not enlisted in terms of support for the staff.

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Q. Thank you. If I could go back, then, to your appearance before as of last week, and I am referring, Mr. Commissioner, to





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Volume 82, I do not believe there will be any need to refer to it, but at that time you told Ms. Cronk that you acted in many ways as a liaison between the nursing staff and the cardiologists; is that correct?

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A. Yes.

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Q. In terms of that, I think you have indicated that you would have contact primarily with the ward chiefs when they were on call, although you also had a monthly meeting with Dr. Rowe?

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A. That is correct.

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Q. Now, I note that from the testimony you have already given before this Commission in the middle of August you approached Dr. Freedom because of the concerns raised by Nurses Trayner and Nelles about the deaths of the babies, and at that time I understand you approached him because you hoped that his information about the autopsies would help these nurses come to an understanding of the cause of deaths of the children. I also note with some interest that Dr. Freedom was ward chief from the middle of August of that year. This, I would understand, gave rise to his discussions with Dr. Rowe and the setting up of the September 5th meeting; is that your understanding?





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A. I am not sure that it is that  
cause and effect.

Q. You had also gone to Dr. Rowe  
and he ---

A. No, but I think that Liz  
Radojewski, and that was the meeting I believe  
the end of July, that she had spoken with Dr. Contreras  
who was the Cardiology Fellow at that time, raising  
nursing concerns as well. So it may have come to  
Dr. Rowe's attention through other routes as well.

Q. I see. By and large, though,  
I think you would agree with me, and we have had some  
opportunity to get to know in a very different forum,  
but get to know both Dr. Rowe and Dr. Freedom, would  
you agree with me that they were approachable  
individuals?

A. Very much so.

Q. Would you find, given your  
communications with them, that they were responsive  
to your concerns?

A. Yes.

Q. So the meeting of September  
the 5th was set up. There was another meeting, we  
know, that was scheduled and was held on September  
the 26th, and I understand that you were not present





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at either of these meetings.

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As a result of them, however, and  
in your discussions with nursing, can you give  
me some idea of what the feedback, to use the term,  
was as a result of the meetings?

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A. The nurses felt that they  
better understood the medical problems of the children  
and what had happened around the ---

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Q. Did they find the response  
of the doctors supportive?

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A. Yes.

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Q. And basically what had been  
sought?

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A. Yes.

Q. Now again, yesterday morning  
we went to Exhibit 300, and again at the end of  
that book, page 175 there is reference to an October  
23rd meeting. In terms of the October 23rd meeting,  
you told Ms. Cronk yesterday -- this is in Volume 84  
at page 8256 -- the question was asked of you by  
Ms. Cronk, and I am reading about a quarter of the  
way down the page:

"Q. Can you help me please as  
to what frustrations were that were  
identified at that meeting concerning







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"the arrests which had been occurring  
on those two wards?

A. The frustration was that in  
spite of their attempts at resuscitation  
that the children had not survived.

Q. And was it perceived that that  
was continuing to be the case not-  
withstanding the meetings and the discussions  
that had taken place at the two  
mortality meetings in September?

A. Yes.

Q. Was there still a concern on  
the part of nursing staff at that  
time, that is October 23rd, 1980, as  
to the number of deaths that were  
occurring?

A. Yes."

Now, I merely raise this in terms of what we know  
of the numbers of deaths, and because of Mr. Scott's  
insistence, I have a handy little chart which tells  
me when the babies died. I note, and I am sure  
my friends will correct me should I be wrong on this,  
but I note that in the months of September and  
October there was a considerable decrease in the  
deaths.





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In the month of September we have Laurette Heyworth who dies September 2nd and I think she was an older child, is that not correct? Are you familiar? You're not familiar?

A. I can't recall.

MR. HUNT: I'm sorry, do we have the chart?

THE COMMISSIONER: Well, we've got another chart, if you want to look at page 44 of Exhibit 3. I don't know if you can deliver that chart or not but I would insist on getting paid for it.

MS. THOMSON: I would think so, sir. I think it is also contained, as Ms. Cronk indicated, in the Prima Facie Statement of Facts.

THE COMMISSIONER: Yes, it is on page 44. You are quite right, Laurette Heyworth followed by Brian Gage, Richard McKeil. Brian Gage and Laurette Heyworth are the only two in September.

MS. THOMSON: That is correct. And then in the months of October we've got Richard McKeil and the Adamo baby and Francis Volk. I'm just looking for some indication perhaps as to why there were concerns and frustrations again in the October 23rd meeting given that you have just indicated to me that the feelings were positive following the September 26th





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meeting and given that it does seem that the deaths decreased to what might be a more expected number.

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Can you give us any insight into the comments contained in that entry at page 175?

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A. My feeling would be that

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additional deaths reiterate those same concerns and that they continued to question their nursing role

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and what they were doing in spite of the reassurances that had been given and I think the comments about

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frustrations concerning communication blocks with the physicians, the summary that was done by the 4B staff

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about that same meeting commented on the doctors

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not communicating to nursing staff soon enough how sick the children were.

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Q. All right.

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A. And I believe we did cover that yesterday.

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Q. But there was nothing specific

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that had occurred during that period that you can direct our attention to?

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A. Not that I am aware of, no.

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Q. No.

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A. Again, I think it was a combi-

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nation of stresses if you will and the deaths of the children being one.

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Q. But would the deaths, two in September and three in October, would those, from your years of experience, be an alarming number?

A. Not alarming but that is significant.

MR. SHANAHAN: I didn't hear, not alarming but what?

THE WITNESS: But significant.

THE COMMISSIONER: But significant you said?

THE WITNESS: Yes. But perhaps I should qualify that as well that one death is significant.

MS. THOMSON: Q. Indeed. I wonder if I could turn now to the topic of rounds. We have heard a great deal about rounds and in fact in Dr. Rowe's cross-examination by Mr. Scott, and I am merely, for the assistance of my friends would give the reference, that can be found at Volume 20 and it runs from pages 3538 to 3600. We have had some considerable discussion about the role of rounds and the cardiologists role in rounds and I wonder if while we have a member of the nursing staff on the witness stand if I could just run through some of those rounds in which nurses would participate.







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Now, as I understand it, there are  
nursing rounds?

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A. That is correct.

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Q. Those are just with the nursing  
staff?

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A. Yes.

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Q. And who would be present at  
those?

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A. Primarily a nursing round would  
happen after report in the morning.

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Q. Yes.

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A. And it would usually be the  
head nurse and the team leader. They would do a  
walk-around round.

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Q. This would be ward specific?

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Q. All right. Now, I also had an  
indication that the head nurses and the team leaders  
meet subsequently with the residents and indeed  
with yourself, is that correct?

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A. When I could make it, yes. They  
did routinely.

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Q. There are also, as we have  
heard from Dr. Rowe, cardiology rounds. These would  
be twice a week, am I correct?





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A. The regular ward cardiology round?

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Q. Well, I'm thinking at the moment of the teaching cardiology rounds.

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A. Yes.

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Q. And present at that would be the cardiologists and the cardiology fellows, all the residents and the head nurse or the team leader?

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A. That is correct.

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Q. And I understand it Monday was also a fairly busy day because you had two meetings; you had one which looked to the week coming and one which was a weekly review. I wonder if perhaps you could describe those for us?

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A. The Monday morning meeting was a combined cardiology and cardiovascular surgery round. In that meeting generally they would review the angiograms of the children who were scheduled for surgery that week.

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Q. Yes.

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A. They then would go to X-ray, see the X-rays of all of the cardiology and cardiovascular surgery patients, then do a walk-through round and discussion in the Intensive Care Unit and then go to the ward.

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Q. Yes. And the ones in the afternoon?

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A. In the afternoon meeting it was a combined round of the cardiology staff and the total cardiovascular staff and they would review the angiograms of children who had been catheterized the previous week and make decisions about whether indeed they would need surgery and if so when would that be done.

Q. All right. Now, did nurses participate in these two Monday rounds?

A. Nurses from the ward, either the head nurse or the team leader would go around in the review of those patients.

Q. Right.

A. I generally attended those rounds; not the Monday afternoon rounds but the Monday morning rounds.

Q. All right. Now, there were also I think pathology conferences, is that correct?

A. Yes.

Q. And would the nurses be invited to attend those pathology conferences?

A. They were invited.

Q. And then of course we know that every morning at 8:30 there is another major round and one of the purposes of that is to review





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any deaths from the night before, from the day before,  
is that correct?

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A. The primary purpose is to  
review the catheterizations of the children from the  
day before but there would be any discussion of  
particular problems at that time.

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Q. And I think we have heard from  
Dr. Rowe that those are fairly freewheeling discussions?

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A. Yes.  
Q. And part of that is encouraged  
in a teaching hospital?

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A. Yes.  
Q. Participation is very much a  
part of learning?

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A. Yes.  
Q. Did nurses attend those?  
A. They were invited to attend, it  
was a difficult time of day for them to be freed up,  
so, very rarely.

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Q. Now, as I understand it, they  
would be held at 8:30, approximately?

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A. Yes.  
Q. When would the long night shift  
end?

A. Their report would be at 7:15, so,







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usually the nurse left the ward at about quarter to eight.

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Q. But presumably if a nurse did

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have particular concerns about a particular baby

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she could attend the morning conference and hear the

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discussion of the child by the cardiologists at that

8

time?

A. She could.

9

Q. Thank you.

10

A. It was not recommended if she

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needed to work the next 12-hour shift the next night.

12

Q. I wonder if I could turn for a

13

moment to a matter that was raised by Mr. Young this

14

morning and that is with respect to the incident

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report that was filed on Baby Gage? I believe,

16

Mr. Commissioner, that is Exhibit 308 and as we

17

know we are somewhat limited in copies. Nonetheless,

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THE COMMISSIONER: It is Exhibit 308.

19

MS. THOMSON: Q. I wonder if we could

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turn perhaps to Exhibit 61 which is the medical

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chart on Baby Gage? I note in particular that this

22

incident report --

23

MS. KITELY: To interrupt my friend,

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could my friend wait until the witness also has the chart.

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MS. THOMSON: I'm sorry, I would be happy to.

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Q. If I could just look at Exhibit 308 for a moment, which is the incident report. My understanding is that the nature of this medication error was double-dosing - I will get to a page number in a moment.

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A. Thank you.

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Q. That was a double-dosing and, that is, there was an amount given, the prescribed amount was given at 0530 hours on the morning of the 24th of September because the child was scheduled to have a digoxin level taken and then subsequently in error there was another dose administered, as would normally be the case, at 9 o'clock in the morning. Is that your understanding of Exhibit 308?

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A. Yes.

Q. Now, if we could for a moment

turn to page 126 of the Gage report. That, Mr.

Commissioner, you will note is one of the lab print-outs with respect to this chart. In the first column which has a date entry of September 24th, 1980, and a time collection of 1600 hours there is a digoxin level reported of 3.5. I am merely asking you, Ms. Browne, if you would agree with me





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that although this level is somewhat high we have heard from cardiologists and pharmacologists that the level is not unduly alarming and that although the child did receive an extra dose it would seem that in monitoring the child's progress by doing the digoxin level there is nothing particularly alarming about that?

A. I would agree.

Q. And I think to be fair that becomes a matter of issue because my record indicates that the Gage child died at 0400 hours on September 25th, which would be some 18, 19 hours after the final administration of digoxin the morning before?

A. Yes.

Q. And we have intervening in that a digoxin level which is not unduly alarming?

A. Yes.

Q. If I could then --

THE COMMISSIONER: The funny thing about it is that the incident report was made at 1800 hours and this test seems to have been taken at 1600 hours. So, it doesn't follow that the test was taken because of the incident, but perhaps I'm wrong.

MS. THOMSON: Well, Mr. Commissioner, the test was indeed scheduled on this baby and that





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is why the baby received the dose at 0530.

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THE COMMISSIONER: The test was  
scheduled, isn't that right?

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MS. THOMSON: Yes.

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THE COMMISSIONER: But it would have  
been scheduled for some time around 10 or 11 in the  
morning, would it not?

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MS. THOMSON: Well, presumably at 0900  
hours, yes.

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THE COMMISSIONER: Well, some time  
around then and that's why they take it earlier but  
in fact it didn't happen. In fact, they never took  
the test at 9 or 10 o'clock in the morning.

14

MS. THOMSON: Well, perhaps we could  
ask the witness.

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Q Although the incident report  
was filled out, and I confess Mr. Commissioner, I am  
not exactly sure - oh, I see, down at the bottom.

18

19

THE COMMISSIONER: Down at the bottom  
it seems to say --

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MS. THOMSON: 1800.

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THE COMMISSIONER: And this blood  
sample seems to have been taken at 1600.

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MS. THOMSON: Q Well, could I then  
ask the witness that if the error did indeed occur







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at 0900 hours, although the incident report was not filled out, would it be reasonable to presume that steps were undertaken to monitor that child, that the filling out of the paper doesn't necessarily coincide with knowledge amongst staff of the incident occurring?

A. I would agree.

Q. Again, if we may for a moment stay on the topic of medication errors. This is a matter that was raised yesterday morning and I would refer you again to Exhibit 300, which is the ward meeting and Communications Book. I am looking in particular at page 64. That is the entry of the 18th of November and I confess that I have the same problem as Mr. Young in understanding when months are put into numerical value. But if I read across there I would understand that there are four medication errors recorded; one on October 6th, one on October 10th, another at October 15th and another on November 7th. Would you agree that that would be a correct reading of that?

A. Yes.

Q. Now, again, I have the advantage of this chart but I think again from the Prima Facie Statement of Facts we can determine that the only one





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which may be of some consequence is the October 15th one. The October 15th one is perhaps of note because that is the date on which Richard McKeil died. Nonetheless, if we look at the McKeil chart, and this is Exhibit 62 at page 80, it is noted at that time that the time of death of the child is 0426. If I look at this exhibit, Exhibit 300, it would seem to be the similar type of error that the dose was supposedly administered at 0530 hours because a digoxin level was to be taken and in error a subsequent dose was administered at 0900 hours. But the only connection, I would submit, that that would seemingly have no connection as the only baby who died at the same time was Richard McKeil and that child unfortunately had died prior to 0530 hours.

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So, although we don't have it identified, would you agree with me that it is unlikely that that child was one who was administered digoxin in error?

A. Given those circumstances, no.

Q. I think in looking at those five digoxin errors that we followed up on, it is perhaps worth to note that most medication errors are not fatal, would you agree with that?

A. Yes.

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3 Q. And that to a greater or lesser  
4 extent we concede that in this form there is a  
5 system that is at work through instant reports,  
6 through notations being made, and that babies indeed  
7 are monitored following any knowledge of medication  
8 error?

9 A. Yes.

10 Q. Could I turn us back to  
11 Exhibit 300, and I'm going to go to the front of  
12 this book, and this, Mr. Commissioner, is where I  
13 was making reference to page 5, and that is the  
14 entry approximately a quarter of the way down page 5,  
15 and that is the entry in which the child Amber  
16 Dawson is discussed, and it is noted that:

17 "News of cause for Amber is still  
18 unknown post mortem was done yesterday."

19 Now I think there is a notation on  
20 the side which says:

21 "...talked to Carlos..."

22 And you indicated to us that you believed that was  
23 Carlos Contreras who was a Cardiology Fellow.

24 A. Yes.

25 Q. And I merely want to ask you  
that given that there was an element of surprise in  
that death, and given that the post mortem was done,





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there is a followup is there not on page 6 of that report?

A. Yes.

Q. And indeed following the post mortem I presume if it is entered in the ward communication book there was a communication to the nurses as to the cause of death of this child as at that time it could be best explained by the pathologist?

A. Yes.

Q. Just one more area that arose from your questioning yesterday, and that refers to Exhibit 302 which is the memorandum from Mr. Snedden, who is the Executive Director of the Hospital. That relates to the calling of Code 25's and the individuals who are to be notified in the case of a Code 25 being called. We know that that memo was superceded a few weeks later, and at that time it was indicated that digoxin levels too were to be taken at the death of any of these children.

You indicated yesterday in examination by Ms. Cronk that between the period of March the 22nd and when Exhibit 302 was put out, on March 30th, you were unsure of the procedure that was in place at that time. I would merely like to clarify a point, Mr. Commissioner, at page 157 of the Dubin







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3 Report, it is indicated by that Commission that  
4 digoxin levels were taken on all patients post mortem  
5 from March 25th, 1981 and onwards. Those are my  
6 questions, thank you very much.

7 THE COMMISSIONER: I am just going  
8 to ask you, Miss Chown, not necessarily call on you,  
9 have you any questions?

10 MS. CHOWN: I have no questions.

11 THE COMMISSIONER: All right.  
12 Mr. Knazan, have you questions?

13 MR. KNAZAN: Yes, I do,  
14 Mr. Commissioner.

15 THE COMMISSIONER: Would you prefer  
16 to start now or would you prefer to start after  
17 lunch?

18 MR. KNAZAN: I would prefer to start  
19 now.

20 CROSS-EXAMINATION BY MR. KNAZAN:

21 Q. Ms. Browne, I represent  
22 Mrs. Christie. You rejoined the Hospital in 1975,  
23 is that correct?

24 A. Yes.

25 Q. And from 1975 to 1982 you were  
in the same position?

A. Yes.





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Q. Is it correct that in that position you had very little contact with bedside care by the nurses?

A. Very limited.

Q. In Exhibit - in the job description which you provided to us, I believe one of your functions is practical nursing, is that correct?

A. Yes, it is entitled "Practitioner".

Q. Practitioner, what is contemplated by that?

A. It was some direct involvement with particular patients or with particular nurses around the care of particular patients?

Q. But it didn't include ongoing care of a patient?

A. No.

Q. And to summarize your lengthy evidence, part of your lengthy evidence with Ms. Cronk, would it be fair to say that there is divergence between the policy manual, Exhibit 291 and the practice on the wards as you know it?

A. Yes.

Q. Now how would the Policy Manual, Exhibit 291, come to a nurse or an RNA's attention?





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3 For instance it is dated March 1977, when Mr. Olah's  
4 client was hired, in 1980, how would this first  
5 be brought to her attention?

6 A. It is part of the orientation  
7 for all nursing staff.

8 Q. Are they given a copy?

9 A. Pardon?

10 Q. Do you know if they are given  
11 a copy?

12 A. No, they are not, it is a  
13 large black volume and it is kept on the ward.

14 Q. So they refer to it?

15 A. Yes.

16 Q. And are encouraged to read it?

17 A. Yes.

18 Q. But as you have admitted even  
19 if they did read it that would not necessarily  
20 describe what their functions were to be?

21 A. True.

22 Q. So they would learn those  
23 functions probably from the nurses who are already  
24 on the team.

25 A. Initially from the teaching  
team leader who does her orientation, which is  
fairly extensive on that ward, before they actually





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assume patient care responsibilities. Once they have assumed patient care responsibilities it would become the responsibility of the team leader and other members of the team.

Q. Now in chief you testified, and again to Ms. Kitley, that the RNA is allowed to care for a child who is on IV?

A. Yes.

Q. And you have talked to Mr. Brown about the IVAC, is that correct?

A. Yes.

Q. And you indicated that the IVAC shows how many drops are going per minute?

A. It controls.

Q. It controls it in general?

A. Yes.

Q. Does it also notify the nurse who is caring for the child when the buretrol is empty?

A. It notifies of any change in the flow of drops through the drip chamber and it may indeed because the buretrol is empty?

Q. In fact if the buretrol were empty it would be too, is that correct?

A. That is correct.







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Q. And if an RNA were caring for a child on intravenous and the IVAC beeped, as you understand the practice and what the RNAs are allowed to do on the wards, what would you expect the RNA to do in that situation?

A. To notify the RN who would then fill the buretrol.

Q. In view of the fact that the manual does not correspond to the practice and that you did not have much bedside experience from 1975 to 1982, and that you have testified that RNAs are allowed to care for children on intravenous.

A. Yes.

Q. If I were to suggest to you that I am instructed that an RNA is allowed and in fact does fill the buretrol from the IV bag when the IVAC beeps, would you be in a position to disagree with that?

A. In terms of the actual practice?

Q. The actual practice.

A. I would have to stand corrected.

Q. So having agreed to stand corrected.

THE COMMISSIONER: He stated that





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to you, and if it is true, that's all.

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THE WITNESS: Yes.

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THE COMMISSIONER: You don't have  
to stand corrected, but if that is so; your question  
was, would it surprise you?

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THE WITNESS: No.

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THE COMMISSIONER: Why not?

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THE WITNESS: I could see that  
happening as a function of a busy unit.

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THE COMMISSIONER: I see, all right.

11

MR. KNAZAN: Q. In view of that  
last answer I just want to know if you will  
slightly modify parts of your evidence that  
you gave in chief and to Ms. Kitley. I don't  
suggest that there is a great difference between  
your answers and the practice.

16

17

You testified for instance to  
Ms. Cronk, and my friends this is Volume 82, last  
Thursday, page 7843, and I think I will start at  
7842.

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THE COMMISSIONER: 7842?

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MR. KNAZAN: 7842, at line 13.

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Q. You were talking about RNAs:

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"A. She could observe the intra  
venous and the site where the

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"intravenous goes into the patient  
but she had no responsibility for  
what was actually done to the IV.

Q. Could she start it or discontinue  
it or in any way adjust the flow of  
the IV medication?

A. No.

Q. Was she then to have any  
direct contact in other than an  
observational sense with the IV  
apparatus at all?

A. No."

Is it your evidence today that it is  
possible that an RNA might have direct contact in  
the sense of filling the buretrol from the IV bag?

A. It is possible, but based on  
my knowledge of policy and practice what I stated  
before would still stand.

Q. And then again at 7843, line 10  
where Ms. Cronk says:

"Q. And in practice once again  
does a registered nursing assistant  
in any way deal with the IV solution  
bag or the IV solution bottle on an  
IV apparatus?

A. No."





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So if the suggestion I put to you turned out to be correct, that the practice was that they could empty the IV bag you would modify that answer?

A. I would. Could I suggest that either a reference to the head nurse or to the teaching team leader about actual practice will be more appropriate?

Q. Okay, thank you.

THE COMMISSIONER: Would this be a good time?

MR. KNAZAN: Yes, this would be a good time.

THE COMMISSIONER: Until 2:30.

MS. KITELY: Mr. Commissioner, could we poll the people who are here to examine the witnesses and see whether we are now going to finish today or tomorrow.

THE COMMISSIONER: Yes. Mr. Olah. I had better first of all --

MR. KNAZAN: 20 more minutes, Mr. Commissioner.

THE COMMISSIONER: Mr. Olah?

MR. OLAH: Like I suggested yesterday about 20 minutes.







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THE COMMISSIONER: Mr. Labow?

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MR. LABOW: I expect to be half an  
hour, Mr. Commissioner.

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MR. SHANAHAN: 15 minutes,

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Mr. Commissioner.

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THE COMMISSIONER: That pretty

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well takes it this afternoon, I don't think there  
is much chance of finishing even if we sit late.

9

I think what we will do, we will try to get through,  
and then Mr. Brown wants some more time too.

10

11

MR. BROWN: If you perhaps can give

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me 5 minutes this afternoon.

13

THE COMMISSIONER: Yes, all right.

14

We will give you 5 minutes at 2:30. The reason I

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am doing that is in case your fear turns out to

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be a rational one, I would like you to be able to

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correct it right away, that's all. So I think we

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will put you on at 2:30. I doubt if we will finish

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this afternoon, but I take it we will have no

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trouble finishing tomorrow.

21

Miss Kitley, I am looking at you,

22

and how long would you be when you come back at it,

23

you don't know yet?

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MS. KITELY: I don't know, but it

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will be brief.





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THE COMMISSIONER: Miss Cronk?

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MS. CRONK: 15 to 20 minutes,

Mr. Commissioner.

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THE COMMISSIONER: Well I think we

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can readily - if we get almost all of the evidence

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done we can finish you two tomorrow morning, is

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that reasonable?

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MS. CRONK: I would think so, sir.

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THE COMMISSIONER: All right, until

2:30 then.

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---Luncheon recess.

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---Upon resuming.

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THE COMMISSIONER: I wonder, Mr. Knazan, if we could dispose of Mr. Brown so we will get him out of the way; is that agreeable to you? You had five or ten minutes and you do not interrupt this ---

MR. BROWN: I am quite content to go after Mr. Knazan is finished.

THE COMMISSIONER: All right. Then we will finish Mr. Knazan.

MR. KNAZAN: Thank you.

Q. Ms, Browne, was a RNA ever assigned a patient under constant nursing care?

A. I do not recall so.

Q. If a registered nurse was assigned a patient under constant nursing care, would it usually be the RNA who was to relieve her?

A. Not usually.

Q. Usually it would be another RN?

A. That is correct.

Q. So either an RNA on constant nursing care or a RNA relieving on constant nursing care would not be the most satisfactory situation?

A. That is correct.





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Q. Now, I would just like to turn to what an RNA can and should do. A RNA is required to take vital signs; is that right?

A. That is correct.

Q. And that includes what?

A. That is heart rate, respirations, temperature and blood pressure.

Q. And also to feed the patient?

A. Yes.

Q. And to monitor the IV if on IV?

A. Yes.

Q. Now, the heart rate, is that the same as the apex or apical rate?

A. Yes.

Q. As you indicated in your testimony, at No. 14.16 of Exhibit 291, the extracts from the Policy Manual --

A. Could I ask the number again, please?

Q. Yes, 14.16. There is no page number.

THE COMMISSIONER: 291?

MR. KNAZAN: Q. 291. Do you see No. 2 under 14.16? That is 292 in your hands.







1 THE COMMISSIONER: What number, I  
2 am sorry?

3 MR. KNAZAN: Q. 14.16, No. 2:  
4 "If the apical rate is less than  
5 60, the dose of digoxin should be  
6 held until the doctor is notified."

7 A. That is correct.

8 Q. And as we know, many of  
9 the patients on 4A and 4B are on digoxin?

10 A. That is correct.

11 Q. So it would often be the  
12 case that a RNA would have patients on digoxin?

13 A. Yes.

14 Q. Therefore, since she had to  
15 take the apical rate as part of her duties, it would  
16 be her duty to notify -- to order a hold of digoxin  
17 until the doctor was notified if the apical rate  
18 was under 60?

19 A. No, the registered nurse  
20 who was responsible for giving the digoxin would  
21 check the apical rate.

22 Q. But it would be the RNA who  
23 would be checking it on an ongoing basis, the vital  
24 signs?

25 A. That is correct, yes.

Q. So she would have to be





1  
2 familiar with 14.16, No. 2, and if it dropped below  
3 60 she would have to notify the RN?

4 A. Well, the apical rate was  
5 taken just prior to administration of digoxin, so  
6 even if the RNA had taken the apical rate and  
7 indeed she would let the RN know that, but the RN  
8 would also check the apical rate before making that  
9 decision.

10 THE COMMISSIONER: But it does not  
11 say so, it does not require the RN before  
12 administering digoxin. The RN can do oral administration,  
13 am I right, of digoxin?

14 THE WITNESS: That is correct, yes.

15 THE COMMISSIONER: But it does not  
16 require her before doing that to check the apex,  
17 does it?

18 THE WITNESS: It does not state  
19 so in the policy, no.

20 THE COMMISSIONER: I would like to  
21 get a job after I get too old for this sort of thing, just  
22 defending nurses because it is one of the easier  
23 jobs around, I think, the way these are written.

24 THE WITNESS: Perhaps it would be  
25 more helpful to do the re-writing, sir.

MS. KITELY: We appreciate all the





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help we can get.

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MR. KNAZAN: Q. At least that is one example of a RNA's connection to digoxin or requirements to know about digoxin?

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A. Yes.

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Q. Can you think of anything else that a RNA would ever have to do with the drug digoxin?

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A. No.  
Q. Just for information, I understand and I would like to know if you are aware of this, that in August 1982 there was a revision of the Policy and Information Manual, Department of Nursing.

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A. Yes.  
Q. And I am also advised, though I do not have a copy and we might be able to get one, that at 14.00, No. 3 of the revised document, and 14.16, No. 2 of this document has been somewhat varied in that if a child is under two years old it is under 100 rather than under 60; is that correct?

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A. That is correct, yes.

Q. I am going to another topic.

In one of your answers you referred to report?





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A. Yes.

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Q. Could you explain to us what report is?

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A. It is the conveying of information from one shift to another, and generally, that information is conveyed by the team leader of the shift that is leaving the ward to the complete team of nurses who will be coming on. So she will have a summary of the report of her team members which she will pass on to the oncoming shift.

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Q. During the period in question, July 1980 to March 1981, the long night shift was 7:30 p.m. to 7:30 a.m.; is that correct?

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A. Could you repeat that, I am sorry.

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Q. During the period in question, the long night shift was 7:30 p.m. to 7:30 a.m. the next morning.

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A. They came on at 7:15 until, in essence, 7:45 in the morning.

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Q. What time would report take place for the oncoming nurses?

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A. 7:15.

Q. Were all nurses required to attend report?







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A. All of the nurses that were  
coming on duty.

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Q. Yes.

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A. Yes.

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Q. Now, the evidence is that  
Baby Belanger died on December 28th at 2010; he  
arrested at 1930 and died at 2010. If my client  
was on the long night shift that night, would you  
agree with me that she would probably have been on  
report from the period 7:15 p.m. to 7:45 p.m.?

11

A. Yes.

12

Q. That would be 1915 to 1945?

13

A. Yes.

14

Q. Was report the first thing  
nurses do when they come into work?

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A. Yes.

16

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Q. So there would be no reason  
to visit the wards before that?

18

A. No.

19

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THE COMMISSIONER: She would be on  
report from when? Report means when you are report-  
ing in, I take it; is that what it means?

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THE WITNESS: It is the passing of  
information from one shift to the next.

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THE COMMISSIONER: Yes, and that is ---





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THE WITNESS: So there is a half hour overlap.

THE COMMISSIONER: And that is 7:15 presumably to 7:45?

THE WITNESS: Yes.

THE COMMISSIONER: Yes, all right.

THE WITNESS: It did not always take that half hour, but that was the time that was set aside for overlap and communication.

MR. KNAZAN: Q. If a nurse was not on report would that be noticed?

A. Yes.

Q. At the time in question did the nurses and RNAs wear little badges pinned to their clothing with their names on them?

A. Yes.

Q. Did that specify whether they were an RN or a RNA?

A. I do not believe so, no.

Q. So it was just their names?

A. Yes.

Q. Was it generally known by the people on the ward at any one time who was a registered nurse and who was a registered nursing assistant?





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A. Yes.

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Q. Now, Dr. MacLeod the

4

Pharmacologist at the Hospital testified that it would not be unusual to see a doctor or a nurse breaking a medication vial in a patient's room; you would agree with that?

7

A. Generally, yes.

8

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Q. But would you agree with me, given all of your testimony as to what a RNA is allowed to do, that it would indeed be strange to see a RNA breaking a medication vial in one of the patient's rooms?

13

A. Yes.

14

Q. And that would be something that would be noticed?

15

A. Yes.

16

17

Q. Now, you mentioned that a RNA has to take vital signs of the child?

18

A. Yes.

19

Q. And another duty of the RNA would be to feed the child?

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A. Yes.

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Q. During a 12-hour shift, would you agree that if a nurse had six babies to care for that would keep her pretty busy?





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A. Well, hopefully she would not have six babies.

Q. Well, I put it to you, and it will be proven, that on the night of March 21st, 1981 my client, Mrs. Christie, was on long nights and had three in Room 425, two in Room 421 and one in Room 418; would you agree that ---

A. I would suggest to you that those probably were not all babies.

Q. I am sorry, you are right, children.

A. Six children, yes, and could I come back then to your previous comment?

Q. Yes.

A. An assignment of six children on nights was not an unreasonable assignment.

Q. I was not suggesting it was, but would you agree that if the nurse who was assigned the six children was doing all of her duties such as taking vital signs and feeding the children if there were infants among them, that would keep her fairly busy and occupied during that shift?

A. She could be quite busy. Again, it would depend on how many were babies. If they were older children needing vital signs done







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every four hours and they slept, then apart from observing the children, making sure everything was all right, there would not be a lot of particular things to do.

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Q. But depending on how many of them were babies, that might take up some of her time?

9

10

11

A. Yes.

Q. Six children on a shift was not unreasonable. Is it a high amount just the same?

12

13

A. I think that was fairly regular for nights with older children.

14

15

Q. Would it be common that one nurse would have six and the team leader would have one?

16

17

18

A. Yes.

Q. In that case it would probably be constant care, the team leader's one child?

19

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21

A. Not necessarily. Often the team leader would not have a patient assignment at all because she had more administrative tasks to do.

22

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Q. Did you come into work on March 20th, 1981?





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A. Can you tell me what day that  
is?

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Q. That is the Monday following  
the weekend.

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THE COMMISSIONER: March 20th?

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MR. KNAZAN: Q. March 23rd, I am  
sorry.

8

A. Yes, I did.

9

Q. You did come into work?

10

A. Yes.

11

12

Q. Did you have any contact with  
the police officers that day?

13

14

A. I was interviewed by the  
police and I am sorry, I do not know if it was  
Monday or Tuesday.

15

16

17

Q. Are you aware that the nurses  
who work on 4A and 4B have access to lockers in  
the Hospital?

18

A. Yes.

19

20

Q. Are those lockers considered  
the property of the nurses during the time they are  
employed?

21

22

A. Yes.

23

Q. They are assigned combination  
locks; is that correct?

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25





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A. That is correct.

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Q. Were you aware on Monday,  
the 23rd that the police had searched Mrs.  
Christie's and the other members of the Trayner  
team's lockers?

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A. I was not aware of it on  
Monday, no.

8

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Q. So you had nothing to do  
with providing the combination number to the officers?

10

A. No.

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Q. At the meeting on the  
evening of March 23rd, did anyone have knowledge that  
the police had searched those lockers during that  
day?

14

A. No.

15

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Q. Not as far as you could determine  
from the conversation?

17

A. No.

18

MR. KNAZAN: Thank you very much.

19

THE COMMISSIONER: All right, thank  
you. Now, Mr. Brown.

20

MR. BROWNE: Thank you.

21

FURTHER CROSS-EXAMINATION BY MR. BROWN:

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Q. Ms. Browne, this morning  
during the course of his cross-examination, Mr. Young





1  
2 referred you to some notes apparently made by  
3 Mary Costello in regard to a meeting held on Monday,  
4 March 23. Those notes are contained in Exhibit  
5 No. 309. You will recall that he directed your  
6 attention to those notes?

7 A. Yes.

8 Q. If I could direct your  
9 attention again to the bottom of page 4 of those  
10 notes, Mr. Young read to you the following passage:

11 "In retrospect I remember Susan  
12 saying I have got my private legal  
13 counsel from lawyer roommate. I  
14 know I didn't do anything wrong.  
15 I know I measured dig. correctly.  
16 I remember a small amount in syringe,  
17 plunger not far out, one squirt,  
18 checking with Mary Jean, giving  
19 Kevin Pacsai ..."

20 Sorry, I do not know that word,

21 "...right card, right baby. Will  
22 get through this. Must stick to-  
23 gether and support each other."

24 - - - - -  
25







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Do you recall Mr. Young reading to  
you that passage?

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A. Yes.

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Q. I believe you stated that you  
left the meeting early and you do not recall those  
comments being made by Susan Nelles?

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A. That is correct.

9

10

Q. You are aware of course that  
Susan Nelles was charged later that week with four  
counts of murder?

11

A. Yes.

12

13

MR. YOUNG: Is that entirely correct,  
Mr. Commissioner?

14

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THE COMMISSIONER: I think it is  
not entirely correct. It certainly started with one.

16

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MR. YOUNG: I don't think anything  
turns on it but my understanding is that there was  
one charge.

18

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THE COMMISSIONER: One charge, and  
then it became more as time went on?

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21

MS. CRONK: And three more within  
the week on Friday the 27th.

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MR. BROWN: That is my understanding,  
yes.

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THE COMMISSIONER: It is not a





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wild mistake in any event, go ahead.

MR. BROWN: Q. And you are aware that a Preliminary Inquiry was held in respect of those charges?

A. Yes.

Q. You are aware that Susan Nelles was discharged at the end of that Preliminary Inquiry?

A. Yes.

Q. And are you aware that His Honour Judge Vanek gave Reasons for Judgment in that Inquiry?

A. Yes.

Q. Have you read those Reasons for Judgment?

A. No.

Q. If I could direct you to those Reasons for Judgment, in particular a passage starting at page 50 of the Reasons for Judgment given by His Honour Judge Vanek. I will read them to you.

A. Do I need a copy?

Q. I don't think you need a copy, although, it is a long passage, if you wish one we can assist you in giving you one.

MS. KITELY: Could the witness have a copy, Mr. Registrar?





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THE COMMISSIONER: Could she have  
a copy? Do you really think she needs a copy?

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MS. KITELY: I don't have a copy.

5

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THE COMMISSIONER: You don't have a  
copy either.

7

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MS. KITELY: I thought one had been  
made an exhibit already.

9

MS. CRONK: I don't think so, sir.

10

MS. KITELY: If there is another  
one my friend has.

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MR. YOUNG: Mr. Commissioner, I have  
a copy.

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THE COMMISSIONER: Before we go too  
much further, what are we leading to?

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MR. BROWN: Well, we are leading  
precisely to this point, Mr. Commissioner, the point  
of the utterances that Mr. Young put to Ms. Browne  
today.

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THE COMMISSIONER: Oh, and there is  
something that Judge Vanek said with respect to this?

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MR. BROWN: Yes, Mr. Commissioner.

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THE COMMISSIONER: All right. Well,  
perhaps you could just read it to us, would you, and  
tell us what he said.

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MR. BROWN: Certainly. Commencing at

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BB3





page 50.

MS. KITELY: Mr. Commissioner, my friend has indicated it is quite a long passage, could we just have a copy for the witness. I think Mr. Young has a copy.

THE COMMISSIONER: Well, really, he is not addressing the witness at the moment, he is addressing someone else and I don't know why she needs one but if you feel that she must have one then we will give her a copy.

MR. YOUNG: Perhaps I should give it to the media instead, Mr. Commissioner.

THE COMMISSIONER: What's that?

MR. YOUNG: Perhaps the media should have a copy?

THE COMMISSIONER: Well, I don't know. I don't know who it is we are reading it to.

MR. YOUNG: I don't see the point in this, Mr. Commissioner.

THE COMMISSIONER: No, I don't either but if Mr. Brown wants to do it I am going to let him do it.

MR. YOUNG: I suppose it is more expeditious to let Mr. Brown proceed.

THE COMMISSIONER: Well, I don't







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3 think it is necessary, Ms. Kitley, for the witness  
4 to have one. So, would you just read it and we  
5 all assume that he will be reading it correctly and  
6 at the end of it you are to say that's right. All  
right, you go ahead and read it.

7 MR. BROWN: Q. Commencing at page 50  
8 His Honour Judge Vanek states as follows:

9 "It was urged upon me in argument that  
10 there were several utterances made by  
11 Susan Nelles and instances of odd  
12 behaviour during the events leading  
13 up to her arrest that were a reflection  
14 of an aberrant personality that  
15 constituted some evidence of her  
16 guilt in connection with the charges  
17 before. It will be convenient to  
18 pick and consider several items of  
evidence at this point:"

19 Turning to page 55, Item No. 3

20 His Honour Judge Vanek continued:

21 "The next items of evidence are composed  
22 of a series of utterances Nelles was  
23 said to have made at the meeting at  
24 Liz Radojewski's house on Monday  
25 night, March 23rd, 1981. All of these





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3 "utterances were made in the context  
4 of the discussion that ensued at the  
5 meeting about the likelihood of a  
6 Coroner's inquest being held because  
7 of the large quantity of digoxin  
8 found in the body of Kevin Pacsai at  
9 his death. In a rather rambling and  
10 confused account of the discussion at  
11 this meeting, Phyllis Trayner stated  
12 that Susan Nelles had expressed herself  
13 as being 'pleased' that an investiga-  
14 tion was going on. Liz Radojewski's  
15 version was: 'that Sue felt confident  
16 that what they did, their actions that  
17 night were right.' Nelles is also  
18 reported to have said, 'I know it looks  
19 bad for me, but I have done nothing  
20 wrong and I did nothing to be guilty  
21 about.' In the same connection, she  
22 is also reported to have said: 'I  
23 know I didn't give them too much; I  
24 know that I measured it in a 1 cc  
25 syringe. It must have been less than  
that. I know I checked it with Mary  
Jean Halpenny;' and she added: 'Don't





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"'you remember, Mary Jean?' Mary Jean Halpenny confirmed that Nelles had checked the dosage with her. Also at the meeting, a question was raised about legal representation and Nelles mentioned that her roommate was a law student.

All the foregoing statements were made in relation to the likelihood of an inquest being held because too much digoxin had been given to Baby Pacsai. Obviously Susan Nelles felt threatened because she had administered digoxin to Pacsai. Her utterances at the meeting, including the fact that the need for legal representation was in her mind, are entirely normal and consistent with the reactions of a person quite innocent of negligence or wrongdoing, let alone murder."

The question that I would like to ask you, Ms. Browne, is, do you agree with the statement made by His Honour Judge Vanek:

"Her utterances at the meeting, including the fact that the need for legal





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"representation was in her mind, are entirely normal and consistent with the reactions of a person quite innocent of negligence or wrongdoing, let alone murder."

THE COMMISSIONER: I take back what I said to you, Ms. Browne. What you should say, your reply should be 'I agree that is what Judge Vanek says'. Can you try that one out? So, that is what you said, so, I will answer for her that that is what Judge Vanek said. I don't think she should be asked to take what is partly a legal, what is partly a psychological answer to that question. That surely is a question for me, is it not?

MR. BROWN: I agree it is a question for you. However, I submit at the same time, Mr. Commissioner, that she should not be asked or recited evidence of which she has no personal knowledge.

THE COMMISSIONER: I agree with that. Yes, all right. Fine, thank you.

Now, Mr. Olah.

MR. OLAH: Fine, Mr. Commissioner.







CROSS-EXAMINATION BY MR. OLAH:

Q. Ms. Browne, as you probably are aware by now I act for Janet Brownless a registered nursing assistant. Before we go any further, Mr. Commissioner, I would like to tender as an exhibit a letter that was written by counsel for the Hospital, in fact, Ms. Thomson, as to the date upon which Janet Brownless commenced her occupation with the Hospital. Perhaps that might be the best record of the commencement date and I would ask at this time that the original letter be filed as an exhibit indicating that my client commenced employment with the Hospital for Sick Children on August 25, 1980.

THE COMMISSIONER: Yes. Ms. Thomson, did you know that you were writing for the record?

MS. THOMSON: I have seen the letter that Mr. Olah is about to tender. It is indeed the letter that was sent to him on behalf of the Hospital.

THE COMMISSIONER: All right. The Hospital for Sick Children, and what's the date of Ms. Brownless' appointment?

MR. OLAH: Her appointment is August 25, 1980 and I have copies of this letter





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for you, sir, and a copy for all counsel.

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THE COMMISSIONER: Yes, all right,  
thank you. That will be what number?

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THE REGISTRAR: Exhibit No. 310.

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---EXHIBIT NO. 310: Letter from the Hospital for  
Sick Children re Janet  
Browneless' commencement of  
employment on August 25, 1980.

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MR. OLAH: Q. Now, ma'am, I would  
like to take you back to some evidence you have  
given on previous days. As I understood your  
evidence, in practice, not in theory, RNA's,  
registered nursing assistants in practice did not  
give or were involved in giving of medication.

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A. That's correct.

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Q. I think you said that there  
was a rare exception in some instances where a  
registered nursing assistant may have prolonged care  
of a child and a child would have fed better because  
of the relationship with the nurse and that I think  
related to older children rather than babies?

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A. That is correct.

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Q. So that when it comes to  
neonates and younger children I take it the general  
practice, the general rule in the Hospital was that





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RNA's did not give medications of any kind?

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A. That is correct.

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Q. And you have also been very precise about this that certainly when it came to digoxin that RNA's were not permitted by theory or in practice to give digoxin in any shape, form or manner?

9

A. Correct.

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Q. Now, as a result of that, I suggest to you that it would be very unusual for a registered nursing assistant to have medication upon their person?

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A. Yes.

14

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Q. For instance, if a registered nursing assistant were seen in the medication cabinet with some sort of medication in hand, that would be most unusual, would it not?

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Q. And if an RN or a team leader or yourself were to observe such a thing, it is something that you would investigate?

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A. That is correct.

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Q. And I suggest to you that not only would you investigate it but some sort of a report would be made out if there was no satisfactory





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explanation?

A. That is correct.

Q. Now, are you aware of any such reports being made out with respect to registered nursing assistants between July 1st, 1981 and March 31, 1981 on Wards 4A and B?

A. No.

Q. Now, to take it one step further I assume that nursing assistants, RNA's, would not have any reason to carry a syringe because they could not give IV medication?

A. That is correct.

Q. And again using the same logic, were an RNA to be seen in the possession of a syringe, whether it be a 1 cc syringe or a 25 cc syringe it would be most unusual?

A. I would agree.

Q. And something that would be investigated and taken up?

A. Yes.

Q. And similarly if an RNA were observed in the vicinity of a patient with either medication or syringe, that would be something that would be highly unusual?

A. That is correct.







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Q. And again it would be something  
that would be investigated and reported upon?

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A. Yes.

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Q. And I have asked you already  
about any such reports or investigations in relation  
in the area of the medication cabinet. Am I fair  
in stating that you are aware of no such reports  
with respect to RNA's in the vicinity of patients?

10

A. That is correct.

11

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Q. Now, we know that Ms. Brownless  
commenced her employment with the Hospital for Sick  
Children on August 25, 1980. Now, am I fair in  
saying that before she could come on to the ward  
itself she would have extensive orientation?

15

A. Yes.

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17

18

Q. So that she would not be  
permitted to come on the ward and care for patients  
until she had gone through this orientation program?

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A. That is correct.  
Q. Can you assist us at all, ma'am,  
as to the length of the orientation program that is  
involved?

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A. I think that might more  
accurately be addressed to the teaching team leader.  
Shall I speak to impression?





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Q. Well, we would like to have you speak your knowledge if you have any of the length and duration of the orientation program?

A. My understanding is that the first week of their time at the Hospital is spent primarily in classes talking about Hospital policy, talking about procedures on the ward. The second and the third week are in part time class time or orientation time and part time involved in patient care and that is all done on the day shift.

Q. And in the second and third weeks would the training an RNA, would she be under the supervision and care of someone more experienced such an older RNA or RN?

A. Yes.

Q. So that in effect the first time roughly that Ms. Brownless would have actually set foot on to Wards 4A and 4B and cared for patients, that would be under some supervision, would have been some time in early September?

A. That is correct.

Q. And we know that by early September there had been some 12 deaths that had already occurred starting with Woodcock on June 3rd, 1980, Perreault on July 8th, 1980, Bilodeau, July





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22nd, 1980, Taylor on July 27th, 1980, Dawson on  
July 28th, 1980, Hoos on July 31, 1980, Turner on  
August 1st, 1980, Shrum on August 9th, 1980, Kelly  
Monteith on August 19th, 1980, Murphy on August 23rd,  
1980 and Velasquez, the 11th, on August 24th, 1980  
and then we had the child Heyworth, my notes  
indicate death on September 1st, someone indicated  
today that was September 2nd, 1980.

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So that by the time Janet Brownless started working for Wards 4A/4B approximately one-third of the deaths that are being investigated by this Commission had already transpired?

A. That is correct.

Q. Now, I would like to take you back over some matters that you discussed with Ms. Cronk. Between July of 1980 and some time in September of 1980 also. As I understood the first time that you had a formal meeting of any kind with respect to the nurses about stress that was related in part to deaths, occurred when you were approached by Nurses Trayner and Nelles at the end of July of 1980?

A. That is correct.

Q. And subsequently there was a meeting I understand on July the 31st where three deaths were in fact discussed; was that Dr. Freedom that discussed those deaths?

A. I don't recall who discussed it. Could you go back to the notes of that?

Q. By all means if that will help you.

A. I am not sure what it says.

Q. I am sorry, that was a discussion







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you had with two head nurses at the end of July.  
Perhaps on page 5 of Exhibit 300 might help you, I  
may have intertwined two discussions. July 31st,  
1980, page 5: "Short ward meeting", have you got  
Exhibit 300 there?

A. Yes, I do.

Q. And if we drop down to the  
second paragraph, that is the one that has been  
covered with you already:

"Re recent death. News of cause  
for Amber is still unknown. Post  
mortem was done yesterday will get  
more info later but it seems there  
is an element of surprise re her  
cause of death."

I am sorry, I was not here yesterday  
when you indicated who was present at that meeting?

A. I don't think I did indicate  
that yesterday.

Q. All right.

A. And indeed it was a short ward  
meeting so it would have been members of the 4A  
nursing staff that were on that day, and I can't tell  
you who was there.

Q. But that is separate and apart





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from the meeting you had with the two head nurses that discussed the element of stress that the nursing staff was suffering on Wards 4A and 4B at that time?

A. Yes.

Q. And in fact that stress and concern increased because after the death of Lillian Hoos on July 31st, 1981, Nurses Nelles and Trayner approached you and in fact were concerned about that death?

A. Yes.

Q. And were concerned as to whether they had done everything that was humanly possible?

A. Yes.

Q. And really that was the tenure of the atmosphere that was developing on the wards; nurses were becoming concerned, as I think you indicated fairly, about the increasing number of deaths and what if anything they could have done to prevent it?

A. That is correct.

Q. In fact, after you met with Nurses Nelles and Trayner you had an informal discussion with some other nurses in the coffee shop?

A. It was with those same nurses.

Q. Was it with the same nurses?





CC. 4

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A. Yes.

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Q. Were there additional nurses

4

present in addition to Nelles and Trayner?

5

A. I believe Janet Beed was.

6

Q. And I think you said that the

7

content of that discussion related to stress,

8

competence, and what if anything they had missed

9

regarding the deaths that had occurred in July?

10

A. That is correct.

11

Q. And in fact the concern about

12

the deaths, and the stress, was such that you spoke

13

to Dr. Freedom and asked him to review a number of

14

deaths in July?

A. Yes.

15

Q. Am I correct?

16

A. Although I have a clear memory

17

of approaching Dr. Freedom in the middle of August.

18

Q. All right. But the concern was

19

to review a number of deaths that occurred in July?

A. Yes.

20

Q. And of course the reason for

21

that was because the nurses were concerned about

22

these deaths occurring?

A. Yes.

23

Q. And whether they had done every-

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CC.5

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thing possible to prevent those deaths?

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A. Yes.

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Q. And in fact Dr. Freedom held

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such a discussion I think you said some time in August?

6

A. Yes.

7

Q. And were there specific deaths

reviewed at that time?

8

A. I believe he reviewed the deaths

9

in July.

10

Q. And the purpose of that

11

discussion by Dr. Freedom was to allay the concern

12

about those deaths?

13

A. Yes.

14

Q. And then I understand that in

15

mid-August there was a meeting between yourself,

16

Bertha Bell, Nurses Trayner and Nelles, concerning

further deaths?

17

A. Yes.

18

Q. And in fact all of this concern

19

about deaths and the stress that the deaths were

20

causing resulted in the request for a psychiatrist

21

to come and intervene and assist the nurses on the

ward?

22

A. That is correct.

23

Q. And in fact you were so concerned

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CC.6

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I think that - was it you that approached Dr. Rowe to have a review of the deaths that had occurred in July and August of 1980 to review them with the nursing staff?

A. I did approach Dr. Rowe about that.

Q. And in fact your intervention was successful, because we know that there was a review that occurred in September, and one of them was on September the 3rd and I believe the other one was on September the 5th, am I correct?

A. I believe September 5th and September 26th.

Q. The 26th?

A. Yes.

Q. So that this was the atmosphere that my client, Janet Brownless, came into in late August, early September, a concern by all of the staff about a rising number of deaths on the cardiology wards?

A. Yes.

Q. Many of these, as we have discussed, occurred before she set foot on Wards 4A and 4B?

A. That is correct.





CC.7

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Q. And a tremendous stress, emotional stress on the ward amongst the nurses resulting from these deaths to such a degree that they sought the assistance of psychiatric help for themselves?

A. That is correct.

Q. Highly unusual, would you agree with me? Have you ever heard of psychiatric assistance being sought by staff, nursing staff on wards before?

A. Yes.

Q. You have?

A. Yes.

Q. It is highly unusual, would you agree with me?

THE COMMISSIONER: I thought she had said it was quite common, but I may be wrong.

THE WITNESS: I don't know if I said it was common.

THE COMMISSIONER: You probably didn't but sometimes I translate people's -- However, perhaps you can tell us what --

THE WITNESS: Could you ask your question again?

MR. OLAH: Q. I am just wondering whether it is normal or abnormal, or unusual, for nurses to request the intervention of psychiatric





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help with respect to stress in their jobs, is that something that in your experience happens usually or unusually? If you can't assist us we will leave it.

A. I am having trouble deciding what words to use. I would say it is not common.

Q. All right. Uncommon?

THE COMMISSIONER: I thought you said it was not common. I don't want to lead you, but I do remember you having said that this had happened before?

MS. CECCHETTO: To assist you, Mr. Commissioner, I believe in cross-examination by Mr. Hunt the witness had indicated that it had happened on two prior occasions I believe where there had been concern with prolonged, children in prolonged care and some nurses had requested --

THE COMMISSIONER: That came before.

THE WITNESS: Yes.

THE COMMISSIONER: It was, you did say something somewhere about the psychiatrist.

MS. CECCHETTO: And she also indicated yesterday I believe about the I.C.U, the intervention in the I.C.U.

THE COMMISSIONER: The I.C.U. had a psychiatrist - at any rate, can you just tell us how





CC.9

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often did nurses require or obtain psychiatric care  
because of the stress, can you explain?

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THE WITNESS: How often they would  
request it?

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THE COMMISSIONER: Yes. All right,  
request or have it, I don't care.

7

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THE WITNESS: It happens periodically,  
again depending on the situation.

9

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THE COMMISSIONER: It certainly  
obviously would depend upon the situation, but how  
often does the situation arise, how often is it? The  
question that is being asked, and I don't want to  
lead you, is is it usual or unusual, is it common or  
uncommon, or can you give us the degree?

15

16

THE WITNESS: In terms of frequency  
I would say that it is uncommon.

17

18

THE COMMISSIONER: Uncommon?

19

THE WITNESS: Yes.

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THE COMMISSIONER: Let us take for  
instance, I take it you move from ward to ward, do you?

23

24

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THE WITNESS: That is correct.

THE COMMISSIONER: Then you can tell  
us pretty well about the Hospital itself, can you?

THE WITNESS: In a limited way.

THE COMMISSIONER: If you had to guess







CC.10

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how many times would psychiatric assistance, or  
nurses under stress be sought and obtained in the course  
of a year at The Hospital for Sick Children?

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THE WITNESS: Well, could I do it by  
ward rather than --

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THE COMMISSIONER: Yes, do it whatever  
way you like.

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THE WITNESS: I don't feel I can speak  
for the whole Hospital. Perhaps I can put it in a  
more meaningful context if perhaps I go back into  
what was raised this morning in terms of what happened  
on 5A as opposed to 4A/B. I would say that probably  
over the course of a year there would be three or  
four situations, primarily patient situations, that  
would be the cause for nurses to seek psychiatric  
consultation around that patient care and around  
their way of coping with it. Those were specific  
instances of request rather than a request for ongoing.

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MR. OLAH: Q. All right, I am not  
sure I understand it, let us see if we can explore  
that for a moment. Would that request be for parents  
and patients, or would it be for the nurses themselves?

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A. Usually in those situations it  
would have begun with a need for consultation for  
a patient and family and then would broaden to nursing  
staff.





CC.11

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Q. In this case the request was  
for the nurses themselves specifically, was it not?

4

A. That is correct.

5

Q. And so would you agree with me  
that that request was highly unusual?

6

A. Yes.

7

8

Q. Now, when you left the Hospital  
in April, early 1983, would you agree with me that  
Janet Brownless was still working on Wards 4A and 4B?

9

10

A. That is correct.

11

12

Q. Now, I want to elucidate some-  
thing with you, because I was somewhat puzzled. You  
have talked now on two occasions with fellow examiners  
about reporting. Do I understand that reporting  
really relates to the new staff coming on at 7:15  
say in the evening, if we are talking about the night  
shift, all night, and what would happen at that time  
is that the team leader, or the charge nurse, would  
review the patient charts for each of the patients  
that those nurses would cover?

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A. Yes.

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Q. Now do I understand correctly  
that that happens on a team or ward basis rather than  
on a combined basis?

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A. That is correct.





CC.12

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Q. In other words nurses from Ward 4A would be briefed with respect to the patients on 4A?

A. Yes.

Q. And the nurses with respect to the patients on 4B would be briefed with respect to the patients on 4B and there would be no interaction between the two reports?

A. That is correct.

Q. So that a nurse presumably on 4A would not know, say for example, about the cardiac condition of a child on 4B, such as Hines or Pacsai?

A. That is correct, not in a formal reporting sense.

Q. Would there be some informal way that a nurse who reports would know that Pacsai and Hines had normal hearts?

A. I can't say specifically that information. What I am saying in a formal sense is that in terms of report, no, it would be reported on the patients for their specific ward. There was sharing of nursing staff at break times, particularly in the evening because they would break at that centre nurses' station.

Q. All right, there would be sharing





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Browne, cr.ex.  
(Olah)

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C.13

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of staff and so someone would go and relieve someone,  
a 4A nurse could go and relieve a 4B nurse?

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A. That wasn't usual.

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Q. But that was not usual?

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A. No.

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Q. But in terms of knowledge, this is what I am trying to get at, in terms of knowledge, generally the nurses would know a high degree, amount about the babies on their ward and would not be terribly familiar with the condition of the babies on the opposite ward?

9

A. That is correct.

10

MR. OLAH: Thank you, Mr. Commissioner.

11

Those are the questions I have.

12

THE COMMISSIONER: Thank you. Mr.

13

Labow?

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MR. LABOW: Mr. Commissioner, before I start I would like to make my request again that this witness' statement be produced to me so that I can review it. I do not know if I will have any questions on it, but it is my position that she has refreshed her memory from it. She has refreshed her memory from it in the witness box, and for that reason it should be released to any Counsel who wants to see it.

22

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In addition, Mr. Commissioner, I would like to put on the record that a number of Counsel who are in my position in that this is not my witness





1  
2 have seen this document, and I have not, and I think  
3 it puts me at a grave disadvantage in my cross-  
4 examination.

5 THE COMMISSIONER: I hear everything  
6 you say. I hear everything you say, and I deeply  
7 sympathize, but I think this is a matter of some  
8 importance and I want to think about it. I invited  
9 you to submit any law on the question to me by the  
10 4th of January. I realize that we are taking a chance  
that Ms. Browne will have to come back.

11 MR. LABOW: Thank you, Mr. Commissioner,  
12 as long as it is on the record.

13 THE COMMISSIONER: It is not only on  
14 the record, it is indelibly printed in my mind.

15 MR. LABOW: Thank you very much.

16 CROSS-EXAMINATION BY MR. LABOW:

17 Q. Ms. Browne, my name is Stephen  
18 Labow and we represent six sets of families in this  
matter.

19 Now, you have told us that you were a  
20 liaison between nursing staff and cardiologists?

21 A. Yes.

22 Q. And that you met on a regular  
23 basis with Dr. Rowe?

24 A. Yes.  
25





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Q. What did you meet to discuss?

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A. Generally the workings of the cardiology service, including nursing and medicine, and particular aspects of care related to the children that I was involved with. So it would be looking at how specific needs of children and families were or were not being met.

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Q. Now, it is my understanding that Dr. Rowe was away for two months in the fall in the period that we are concerned with. Did you meet with anyone else in his absence?

17

18

19

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A. Not to serve the same purpose. For concerns that I had around patient care issues, I primarily dealt with the cardiologist who was on the ward at the time. If it was an issue relating to other than the ward, I would deal with Dr. Fowler who was responsible for clinical services.

21

22

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Q. Now, I am not sure when Dr. Rowe was away, although I seem to think it was in October and November of 1980. Did you meet with Dr. Rowe in September?

A. I cannot recall. I did meet with him the end of August before I went on holidays.

Q. Now, when Dr. Rowe returned, you





1  
2 had already had some of these general concerns about  
3 what was happening on the wards. Did you bring him  
4 up to date at your meeting when he returned in  
5 December or January?

6 A. I do not believe I saw him in  
7 December. I did speak with him in January.

8 Q. Now, when you met with him in  
9 January, did you discuss any of the concerns that the  
10 nurses were bringing to you?

11 A. In a general sense that we have  
12 discussed already.

13 Q. But nothing more specific than  
14 what we had discussed to date?

15 A. No.

16 Q. Now, you have told us that  
17 charting was done at the end of a shift or when the  
18 nurses took a break?

19 A. Yes.

20 Q. Now, would that include  
21 generally all of the notes in the progress notes?

22 A. Usually.

23 Q. So it is conceivable that a  
24 nurse did not put her notes into the progress notes  
25 until 12 hours later?

A. That might be the case, yes.







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Q. How did she recall what went on?

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A. She would use the fluid record work sheet that was at the bedside to document as she went along, and that would refresh her memory when she came to do her charting.

6

7

Q. Now, would she put down other things in that work sheet such as how the child looked?

8

9

A. She might, yes.

10

Q. And that would be her only way of recalling what had happened over the entire shift?

11

A. In a written sense, probably, yes.

12

13

Q. Now, how many children, and I am specifically talking about infants, on an average, would a nurse be dealing with in the evenings?

14

15

A. If she was just assigned to infants, probably three.

16

17

18

Q. So she would have a rather long period of time to recall any specific things about three infants before she charted? She would have a 12 hour gap sometimes?

19

20

21

A. Well, except for what she had written on the work sheet.

22

23

THE COMMISSIONER: Ms. Browne, we have had this out before. What do you mean by an infant?

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What age would you say is an infant?

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THE WITNESS: I would say under one.

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THE COMMISSIONER: Would that include  
neonates?

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THE WITNESS: Yes.

6

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THE COMMISSIONER: Anything under one,  
all right.

8

9

THE WITNESS: And that is not a  
particularly sophisticated definition.

10

11

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THE COMMISSIONER: It is just as good  
as anyone else's. We have had different ones, but I  
think that is a popular one. In law it is 19, and  
that is not months, that is years.

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MR. LABOW: Q. Now, you told  
Ms. Cronk that your impression of what stable meant  
was that the child was not in any danger or was no  
worse off than the child had been?

17

A. Correct.

18

19

Q. You agreed with Dr. Rowe's  
statements that a child can deteriorate rapidly after  
the child appeared to have been stable?

20

21

A. Yes.

22

Q. When that happened did the  
nurses generally get concerned?

23

A. Yes.

24

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Q. Did they generally get as concerned as they appeared to have been in our time period?

3

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A. Yes.

6

Q. Did they come to you with their complaints, concerns?

7

8

A. If there were concerns about the child in question, they would have gone to the team leader and to the physician involved.

9

10

Q. When would they get to you?

11

A. Generally at a later time when things were more settled.

12

13

Q. You have told us that the nursing care plan was a summary of care for the nurses to use?

14

15

A. Yes.

16

Q. And it was written in pencil?

17

A. Yes.

18

Q. Do you know why it was written in pencil?

19

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A. Well, it was a working directive, if you will, so that as plans changed they could be erased and updated.

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Q. Do you know of any other hospital records that are kept in pencil?

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A. No.

Q. Is it standard for hospital records to be made and then thrown away, erased?

A. This is the only one that I know of.

THE COMMISSIONER: Whenever you want, Mr. Labow.

MR. LABOW: I think this is an appropriate time.

THE COMMISSIONER: We will take 15 minutes.

--- Short recess

--- Upon resuming

THE COMMISSIONER: Yes, Mr. Labow.

MR. LABOW: Thank you, Mr. Commissioner.

Q. Now, Ms. Browne, you have told us that Phyllis Trayner and Susan Nelles came to you with general concerns, and at Volume 84, page 8212, you said that their concerns were whether their observations were accurate, whether they had responded quickly enough, whether they had called for medical assistance soon enough, was there something they had missed, and had they realized how sick she was, and this is in reference to Baby Hoos.

A. Yes.







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Q. Now, did they raise any other concerns, specifically did they raise any concerns about the doctors' care in this case?

A. I cannot recall specifically, no.

Q. Did they ever raise any concerns, the nurses to you about the care, the medical care afforded to these children or any of the children by the doctors?

A. I believe there were comments made in the communication book from the October 23rd meeting that referred to that. I also know that over the summer months that is a period following a fairly major resident change in the hospital, so particularly through the months of July and August you have a good number of young residents who may or may not have worked in pediatrics before, and most of whom have not worked in cardiology before.

Q. Now, aside from the October 23rd note that I will get to in a moment, were there any concerns about the doctors that you brought to the attention of Dr. Rowe, for example?

A. Not that I recall, no.

Q. If the nurses had concerns about the doctors, what would they generally do?





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A. If those concerns were to me, usually what I would do would be to help the nurse to see what channels were open to her in that could she approach the doctor involved and let him know how she was feeling. If she was not comfortable with that, could she go to that physician's superior, if you will. I certainly was willing to go with them on those occasions, but I preferred not to be an intermediary.

Q. Now, the meeting of October 23rd, this is Exhibit 301 in the 4B meeting book, on page 9 there is a note and it is the only note that we have referred to concerning doctors.

A. I am sorry, I have not found the page.

Q. It is page 9 in Exhibit 301. This is not the bound one, it is the separate one.

A. Could you give me the page again, please?

Q. 9.

A. Thank you.

Q. At the very top of page 9 there is a note expressing one concern, at least, that the doctors do not relay messages about how sick the children are and then the children die.





DD 11

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A. Correct.

3

Q. And that the fellows need to

4

know more about things about cardiology?

5

A. Yes.

6

Q. Now, was this a general concern

or was this a very specific once only type concern?

7

A. I do not know that I can say.

8

Q. Do you recall having the nurses

9

express this kind of concern to you frequently?

10

A. Not frequently. It did happen

11

occasionally.

12

Q. Now, when you discussed the

concerns that the nurses had at any time with

13

Dr. Freedom or Dr. Rowe, did you ever question the

14

doctors' care with them?

15

A. I do not remember specifically,

16

no.

17

Q. Did either of them ever mention

18

to you that possibly the doctors would review what

19

they did to see if they could have done anything

20

more?

21

A. I do not remember a comment to

that effect. I felt that indeed the doctors were

22

reviewing their care just as nursing were in light

23

of the meetings in September.

24

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Q. If a nurse, not the team leader,

3

but if a nurse had a concern about the death of a

4

child, would she go generally to the team leader

5

before she came to you?

6

A. Yes.

7

Q. So it would be common practice

8

if there was this kind of concern for the nurse and

9

the team leader to be concerned?

10

A. Yes.

11

Q. So for example, in the situation

12

when you were approached by Nurses Nelles and Trayner

13

because Nurse Trayner was the team leader, it would

14

not be surprising, for example, and I am speculating,

15

if Nurse Nelles had a concern, went to her team

16

leader and then they both approached you?

17

A. That would not be unusual at

18

all.

19

Q. In your discussions with them,

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did they ever explain to you which one of them had the

21

concern, if it was only one of them?

22

A. My impression was more that it

23

was a team concern.

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Q. So it was not an individual

25

concern? Your impression was that it was not an

individual concern?







DD 13

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A. No.

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Q. Now, after the discussions in

4

August with the nurses, they had the mortality

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conferences, but in the October 23rd notes for both

6

4A and 4B there still seemed to be concerns and  
frustrations?

7

A. That is correct.

8

Q. So can I take it that the

9

nurses really were not satisfied after the September

10

reviews?

11

A. I think there still were babies

12

dying.

13

Q. Well, were the concerns that

14

they brought forward in October confined specifically

15

to what had happened between the last review in

16

September and the end of October?

A. I do not think so, no.

17

Q. So these were more of an

18

additive type thing, they had the previous concerns

19

and then they had some more deaths and their concerns

20

were still there?

A. Yes.

21

Q. Now, we have heard that there

22

was a conflict between Nurses Trayner and Nelles?

23

A. Yes.

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Q. Do you know if this was in the way of a personality conflict or don't you know?

A. I do not know.

Q. Had they worked together previously on 5A?

A. Yes.

Q. Had they worked on the same team?

A. I do not think I can tell you that.

Q. Did they still have a team approach when the cardiology ward was on 5A?

A. Yes.

Q. Do you know how many teams there were on 5A?

A. Two, I believe.

Q. And when they came down to 4A/B there were four, I assume, or am I wrong?

A. Well, can I go back to my statement about 5A?

Q. Sure.

A. Indeed, there were two teams for each shift on 5A and, indeed, there were two teams for each shift on 4A as well.

Q. So there were four teams





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essentially on 5A and four teams on 4A/B?

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A. Yes.

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Q. Then, why did they change the --

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THE COMMISSIONER: I am not sure that  
that is right.

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MS. CRONK: I think it is four teams  
on each of 4A/4B, if I understood Ms. Brown correctly.

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THE WITNESS: That is correct, yes.

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MR. LABOW: Q. So it went from four  
teams total to eight teams?

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A. That is correct.

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Q. Were a lot of the nurses who  
started on 4A/B new to the Hospital for Sick Children?

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A. With the move to 4A/B?

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Q. With the move.

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A. No.

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Q. Where did they get the nurses to expand the teams from 4A?

A. The teams were smaller. The nurses had a choice of moving to either 4A or 4B, the difference being that 4A had more infants. From questions and comments over the last couple of days I'm not sure whether the nursing quota was increased and if so by how many but that indeed there were concerns with that move about the nursing coverage.

Q. Now, you said the nursing teams were smaller?

A. Yes.

Q. Did they deal with a lesser number of children or infants per team?

A. Yes.

Q. Now, you have explained that there was a conflict and that you were aware of it in October of 1980, is that right?

A. Yes.

Q. Wouldn't it have been easy to replace one of the two nurses with a nurse on another team, just switch one nurse, rather than breaking up all the teams?

A. That still would have disrupted two teams.







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Q. I understand it would have disrupted two teams but if there was a conflict, had this ever been done before, they would just switch one person out?

A. I don't recall that it had but you might direct that to the head nurse.

Q. And this was the responsibility of the head nurse?

A. Yes.

Q. Did anyone ever go further with this problem or was the head nurse just expected to deal with it?

A. I think the expectation was that the head nurse would deal with it.

Q. And if she decided to do nothing it wasn't common to go to the area co-ordinator?

A. No, if the head nurse felt she could resolve the conflict herself it didn't. I can't say whether that information would have been passed along to the co-ordinator.

Q. Did you pass it on?

A. No.

Q. Now, without having looked at it, you have told us regarding your statement that you couldn't really accept the idea at that time that





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all the deaths were from natural causes?

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A. That was given the background that at that point in time we were talking about four infants with high dig. levels.

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Q. Right, at that time.

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A. Yes.

MS. KITELY: Can we clarify, sir, that at that time is July, 1982?

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MR. LABOW: July 9th, 1982.

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THE WITNESS: Yes.

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MR. LABOW: Q. And that you were concerned about the possibility of an unbalanced person walking around that hadn't been noticed?

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A. That was documented.

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Q. And then your conclusion was that, correct me if I am wrong, if these children had died from a massive overdose of digoxin and if the digoxin levels were correct, it must have been a nurse who did it, they had the best access?

A. Yes.

Q. Now, my understanding from what you told Mr. Young and Mr. Hunt was that because a lot of these children were on constant care a nurse would be there at all times?

A. That is correct.





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Q. And therefore she would have the most direct access and control of that child?

A. Yes.

Q. Do you know if anyone looked into that at the Hospital with regard to these deaths?

A. What do you mean looked into it?

Q. To see exactly which children were on constant care and who was caring for them?

A. I'm sorry, I'm not understanding the question.

Q. During the epidemic period, the period that we are talking about, July 1980 to March 1981, do you know of anyone at the Hospital who looked into the deaths on those wards to see which children were under constant care and who was caring for them?

A. During that period of time?

Q. During that period?

A. No.

Q. Do you know of anyone who you are associated with, or were before you left the Hospital, who did that after the fact?

A. Apart from the police?

Q. Apart from the police?

A. No.





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Q. Now, we have heard a lot about medication errors but in your summary, that is Exhibit 305, Mr. Commissioner, on the last page you set out the nine routine steps for the administration of drugs?

A. That is correct.

Q. And prior to the new situation for digoxin where it became a controlled drug, there was still a double-check in existence for digoxin?

A. That is correct, there would be two RNs.

Q. So, two RNs would calculate the dose and two RNs would check when it was drawn up?

A. That is correct.

Q. But my understanding is there wouldn't necessarily be two RNs in the room when the drugs was administered?

A. That is correct.

Q. Notwithstanding all of that, how do you account as the clinical nurse around for the digoxin errors?

A. The ones that we had discussed earlier today?

Q. The ones that we had discussed. What didn't they do?







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A. Indeed, they didn't check the med card, they didn't check the order and they were not familiar with the ward procedure at that point related to holding digoxin or giving the 9 o'clock digoxin at 5:30 when a dig. level was to be done.

Q. Now, these were relief nurses and a student nurse?

A. yes.

Q. And you explained that the student nurse would have been under the supervision of a registered nurse?

A. Yes.

Q. Would a registered nurse on the ward be unaware of the procedure regarding the digoxin levels in giving digoxin at 5:30 instead of 9?

A. If it was part of the staff it would have been an RN and she would have been aware.

Q. Now, we also have a diagram, that is Exhibit 304, of the cardiology ward. Now, the nurses' station at the northern end of the middle, there are three windows on either side?

A. That is correct.

Q. The area between the three windows, is it generally lit up?

A. Yes.





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Q. So, during the evening and the night would the curtains on those windows generally be drawn?

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A. I can't answer that for you.

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Q. So, you don't know if during the evening when the lights are on in the station if they would allow the curtains to remain open so the light would flow into the infant rooms on either side?

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A. I would think that they would.

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Q. Be open or closed?

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A. Be open.

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Q. Yes, they wouldn't be concerned about all this light flowing in through the windows?

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A. The windows weren't that big and they did have a venetian blind type of blind on them so that the light didn't seem that great in the room.

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MR. LABOW: I have no further questions, Mr. Commissioner.

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THE COMMISSIONER: All right, thank you. Mr. Tobias?

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MR. TOBIAS: I am going to allow Mr. Shanahan to go ahead of me. I don't want that interpreted by the press that I am always last to go





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so I won't have to ask so many questions. I am just trying to help him out.

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THE COMMISSIONER: No, but I am going to interpret it that Mr. Shanahan has another date with the Provincial Court tomorrow morning.

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MR. TOBIAS: I think so, he seems to be quite busy.

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MR. SHANAHAN: Right, okay. I've got a thick skin, Mr. Commissioner, to take all this abuse here.

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CROSS-EXAMINATION BY MR. SHANAHAN:

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Q. Ms. Browne, my name is Shanahan and I act on behalf of the Lombardo and Dawson families. I know a lot of this ground has been covered, we are perhaps all covering it from our own point of view or our own clients' interests, so, bear with me if I just take you through some of the areas again just very briefly.

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With respect to the approaches that were made to you by Nurses Nelles and Trayner. First of all, you indicated I think just to Mr. Labow here that you felt it was a team concern that they were expressing?

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A. Yes.

Q. And yet what struck me in your





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evidence the last few days, it is quite clear that as a team they weren't approaching you, it was two ladies, Nurse Nelles and Nurse Trayner, that first approached you and it seems to me continued to approach you with their concerns?

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A. Yes, sir.

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Q. All right. Now, it seems as well that the areas are divided up, they express the stress that they are feeling, their competence as nurses and whether anything else could have been done. That seemed to be the areas that they were expressing their concern about, am I right there?

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A. That is correct.

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Q. And it seemed to me that the stress issue was, as we looked through those memos, the stress issue seems to be the issue that has predominated?

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A. Yes.

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A. Yes.

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Q. And then to follow that up then.







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There is no question that the stress though, I mean, nurses may have stress from overwork, under-staff or what-have-you, the stress here at this time period was purely and simply because of the fact there were a rising number of deaths that they could perceive?

A. No, sir. I believe we did cover that previously and indeed it was related to workload, it was related to their staffing.

Q. All right. It was certainly tied into those issues but I would submit to you, ma'am, that in fact the chief reason for their stress was related, and when they talked about their skill level and their inability to resuscitate these people and get them back to I.C.U., their largest concern here was that as a result of this children were dying?

A. In the approaches that we have talked about in July and August, yes.

Q. All right. I would suggest to you as well, ma'am, that that occurrence, that is, you say that to meet Nurse Nelles and Nurse Trayner at the end of their shift as you might, in the morning, wasn't unusual?

A. No.





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Q. All right. But I put to you that in fact nurses coming to you complaining of stress amongst other things and in July that stress being related to a rising number of deaths, that you haven't had in your career any other similar type of complaints, nurses feeling that too many children are dying in their care?

A. I have had that raised with nursing staff in the Intensive Care Unit.

Q. All right. I am talking now one step removed from Intensive Care because you will agree that the degree of risk there is a lot higher than out in the general ward?

A. Yes.

Q. All right. Well then, bearing in mind that we are dealing with children on the ward per se, I would put to you that you had never had a like complaint before in your career?

A. Can I say that I have dealt with staff around a series of deaths or a run of deaths if you will, where two or three children have died.

Q. You are not comparing two or three now to the 9-month, 36-death period we are complaining about, we are considering here?





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A. No.

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Q. No.

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A. I am comparing that experience  
with that July, August with what was coming forward.

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Q. All right.

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A. And I agree that two or three  
is not the same as ten or twelve.

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Q. All right. To assist you, I  
tell you way many moons ago, and I can't give you  
chapter and verse, that Dr. Rowe said that further  
along the line the complaints that he had got, that  
he started to hear about the nurses' concerns, that  
he had never run into that before ever in his career,  
the complaints about nurses being concerned about  
the rising number of deaths of children in their  
care. Would that surprise you?

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A. No.

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Q. All right. Now, again, I think  
Mr. Labow just touched on this. You say that Nelles  
and Trayner came to you but in fairness as to where  
the true impetus here for the, if you like, the  
complaint or the concern being registered, whether  
in fact Nurse Nelles may well have in fact been  
caring for these children and she may have turned to  
the first line of authority above her being Nurse





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Trayner and that in fact she accompanied Nurse Trayner down to you to be sure that her concern was being registered. In fairness, that scenario could be how the impetus for this whole thing transpired rather than as you described it?

A. That could be.

Q. All right. Both came to you, is your evidence?

A. Yes.

Q. But you don't know one step behind that as to what might have caused both of them to come to you, who might be the first one to really register the complaint?

A. That may be, although, the instances that we have discussed in terms of July and August, those coming to me would be at the nurses' station where they were.

Q. Yes.

A. Physically it was my coming on duty in the morning.

Q. Well, that ties back into my first question. If that is where you're meeting them, and there is four people on a team, what struck me was that two other nurses on a fairly regular basis are not coming to you. Trayner and Nelles are







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coming to you and a lot of them agreeably are in  
Nelles' care?

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A. Yes.

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Q. And they come to you at the end  
of a shift. Am I right there in interpreting your  
evidence?

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A. Yes.

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Q. So, I think put quite simply  
you don't know as between Nelles and Trayner what  
discussions went on prior to that as to who had, if  
you like, the very first concern here?

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A. No.

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Q. No.

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A. Could I also say that the other  
members of the team had other responsibilities for  
covering patient care.

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Q. Yes.

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A. At that time until the nurses  
coming out of report would assume responsibility for  
the patients. So that indeed was very logical to  
me why they were not at the nurses' station and they  
tended to be caring for the older children who were  
starting to get up, who were needing assistance to  
either get out of bed or go to the bathroom or what-  
ever.

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Q. All right. Now, you say that





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the first death that seems to bring the matter to a head is that of Amber Dawson?

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A. Yes.

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Q. All right. I would suggest to you, ma'am, that in fact Amber Dawson's death, as they expressed it to you, and this may tax your recollection of it so bear with me here, but Amber Dawson's death is so sudden and so unexpected that it causes them immediate concern and the two of them immediately approach you the following day. Am I right there?

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A. The sequence was that they did approach the next day, yes.

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Q. All right. And more than just the sequence, is there any expression there as they conversed with you that their feeling on Dawson, whether it be directly from the doctors or by inference, their feeling on Dawson is that her condition is not such that they felt she would die so suddenly?

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A. I think that's true.

Q. All right. Do you know much about the Dawson case, and I am certainly not going to take you through it, but does the name Amber Dawson and her condition in any way as to, we will say, her





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age or whether she was scheduled for surgery, do you  
remember individual --

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A. I had known her for quite some  
time.

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Q. You had?

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A. Yes.

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Q. Did it then surprise you that this 11 month old child who had been largely cared for by her mother over the previous few months had come in there and had not been scheduled for any particular operation and had not come in there as a result of any particularly untoward event, did it concern you or cause you surprise that in fact she had died within five days?

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A. I was surprised having seen her through a number of ups and downs, yes.

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Q. You said that you felt in your recollection that part of their concern as well was their inability to perhaps contact the mother?

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Q. Did I gather correctly from that that their concern was that she may come in expecting to visit Amber and being met suddenly with the news, well, Amber has died in the meantime, is that the gist of it?

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A. Yes.

Q. Could I put to you another scenario. That in fact maybe Mrs. Dawson had been told the news of Amber's death; and that Mrs. Dawson







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was ranting and raving about it and telling them that she was going to demand the coroner get involved; and that in fact these two nurses were beating her to the punch by coming to you?

A. That was not my impression from their communication. I felt they were passing along what they felt was their nursing responsibility because they were leaving the shift and they knew that Amber's mother was still to come.

Q. Well you do know in this case, do you not Ms. Browne, that in fact the impetus here for the coroner being involved, and after all the hospital could have broached the issue of autopsy had they wished, but the autopsy procedure being circumvented and the coroner being involved, you know was because the mother caused - was greatly concerned?

A. Yes, I do.

Q. That short of the mother being that concerned her death was going to be put down again to her anatomical condition?

A. I think because her death was a surprise the cardiologist did indeed want a post mortem done.

Q. A post mortem could have been got through autopsy, but the coroner being involved





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was one step further you will agree?

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A. Yes. The mother's request was for an impartial autopsy to be done, yes, and she wanted the coroner contacted.

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Q. Getting then into another secondary here about the administration of digoxin. You have told us here about how it was administered and the various procedures and protocols. It seems to me that the bottom line was that the digoxin itself was freely available, it wasn't under lock and key during this time.

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A. That is correct.

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Q. But at the same time the other safety check, if you like, was that two nurses would have to be involved in drawing it up and in ensuring that it was the correct dose?

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A. That is correct.

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Q. And I take it then that right there from a layman's point of view, and I would like your input here as a nurse, it seems to me that right there the possibility of error when two trained people must read a label, and I don't care how similar the vials might look, they have got to look at a label with a name on it and then go on and implement the doctor's orders, that the likelihood of

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error, right there, becomes very slim?

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A. That is why it was set up that way, yes.

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Q. Now, I suggest to you as well though that the other side of that protocol is that it presumes of course that we are dealing with someone, or people, or a general administration that is regular and proper and according to doctor's orders. You will agree that if anyone is bad minded enough here to get into any sort of intentional overdose of these drugs that your protocol goes out the window?

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A. Yes.

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Q. So that although it is designed to catch error it seems I suppose it goes without saying in the last few days, that there was nothing here to monitor those people who might go astray?

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A. That is true.

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Q. The whole basis of the system was that nurse number one is going to do the administering, goes and takes nurse number two who will check the procedure?

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A. Yes.

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Q. And if nurse number one is bad minded enough to be overdosing these children, either A she doesn't find nurse number two, or she finds a





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nurse number two is going to be complicit in this administration?

A. Yes.

Q. Now, again in terms of what Mr. Labow put to you about administering to the children are the three errors that you saw there. You will agree here too again your likelihood of error, when you speak of a child like Lombardo, to whom this drug was not to be administered at all; we are not talking about timing; size of dose; therapeutic or toxic, we are talking about the fact that it was never even ordered. You will agree that that would be a huge error to give that child digoxin?

A. Yes.

Q. Dr. Hastreiter has said as well he felt that the dose that Lombardo got was in all likelihood far greater because of the toxicology results that we found in the exhumed tissue, was far greater than one therapeutic dose. So you will agree to give Lombardo, A to give her digoxin at all; and B to give Lombardo a toxic dose, would again be a huge error?

A. Yes.

Q. And then finally, you as a nurse dealing with a child who was perhaps getting one drug,







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heparin, and that one drug heparin was being given by intravenous, that we really have error compounding error when you bear in mind that she has to be given digoxin, she has to be given a toxic dose as Dr. Hastreiter says and she has to be given it by a route, that is orally, which she is getting no other drug by, that really this is error upon error and your chances of this happening are slim to the point of really, I put to you, almost of non-existence?

A. I am sorry, I didn't follow that, and it may be my unfamiliarity with the references you are making to Dr. Hastreiter.

Q. Dr. Hastreiter says that he feels that she got more than one therapeutic dose. That would be, say if she got the does of a baby of similar age and weight, Dr. Hastreiter has said to us the readings that we have found he feels that she has had more, a larger dose than one therapeutic dose. So I suggest to you that is another error. It is not just giving Stephanie Lombardo the drug digoxin; it is not just giving Lombardo someone else's drugs, it is also giving Lombardo a toxic dose that wasn't meant for anybody, you will agree?

A. I am not sure what I am agreeing to.





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Q. And then Dr. Hastreiter said as well --

THE COMMISSIONER: I think that is a fairly good question, but you asked her to agree that is what Dr. Hastreiter said or to agree --

MR. SHANAHAN: No, I think the question before was; you will agree that the error there is twofold, giving her digoxin and giving her a toxic dose.

THE COMMISSIONER: Assuming, if I can just correct this, assuming that Dr. Hastreiter is correct. It does involve more than a therapeutic dose, you will agree with his conclusion that that involves two errors, one giving digoxin when there wasn't to be any given and giving more than a therapeutic dose. Yes, Ms. Kitley?

MS. KITLEY: I think the witness has some knowledge of what has gone on in the last six months, I don't know if she will recall who Dr. Hastreiter is.

THE COMMISSIONER: I just say assuming, the way I rephrase the question, if Mr. Shanahan wishes I will let him put his own questions the way he wants to.

MR. SHANAHAN: I think he did.





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THE COMMISSIONER: The trouble is if you do that the answer is impossible.

MS. KITELY: Is my friend's question directed to error as opposed to the assumption which Mr. Commissioner has indicated, I think that is not clear what the witness is supposed to be doing.

THE COMMISSIONER: I ask you to assume, first of all, that the amount of digoxin in the tissues of Baby Lombardo found, indicate that more than a therapeutic dose of digoxin was given, right, can you assume that?

THE WITNESS: Yes.

THE COMMISSIONER: The second, I ask you to assume the child was not to be given digoxin at all.

THE WITNESS: All right.

THE COMMISSIONER: Then do you agree with Dr. Hastreiter's conclusion that that involved two errors, one error is giving it, the drug to the child at all; and the other drug is given more than you should be giving if you should be giving it to a child?

THE WITNESS: I would agree.

MR. SHANAHAN: Q. All right. Just tagging onto all those assumptions. The third one is





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2 that bearing in mind that she was not to receive any  
3 medications orally?

4 A. Yes.

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Q. For her to be given that  
and assuming Dr. Hastreiter is correct, because he  
felt it was given orally, that would be your third  
error if a nurse were to come in and give her that  
amount of drug orally?

A. I would agree.

Q. All right. Would you as a  
nurse or would any other nurse be familiar with,  
I take it, would be familiar with the size of  
digoxin overdose and toxicity?

A. Yes.

Q. And I take it then it would  
be obvious to any reasonably experienced nurse that  
digoxin overdose and its symptoms would be roughly  
similar to many of the symptoms that these children  
who would die of their own anatomical defects, that  
the two would be roughly similar?

A. I believe so although I  
don't believe I am your best source to confirm  
that.

Q. And finally would a nurse  
be aware what the implications of the term contra  
indicated, a drug being contra indicated for a  
child, are you aware of that?

A. Yes.





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Q. All right then, finally about the conflict that you indicated between Miss Trayner and Miss Nelles. Did you say to Mr. Labow that - you did say you didn't know what the conflict was about?

A. I had a vague awareness of that conflict as was passed on to me by Liz Radojewski.

Q. Yes, can you tell us what it was about?

A. I believe I did that already today.

Q. And I may have missed it, I apologize.

A. It had to do with their working together I believe and their feeling of trust in one another's work; a difficulty in terms of delegating and recognizing the skills and expertise of the other.

Q. And it obviously had manifested itself enough, this conflict and what have you, that Nurse Radojewski had either picked it up or had been told about it by one of the two?

A. I think she had been told about it.





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3 Q. Now, you said yesterday  
4 that, I thought - excuse me a moment, about this  
5 issue perhaps of splitting this team up, if I can  
6 find it here, if you will bear with me for a minute.  
7 It is yesterday's evidence, Volume 84 and it  
8 commences at the bottom of page 8275; have you located  
9 that Miss Kitley?

10 MS. KITLEY: Yes.

11 MR. SHANAHAN: Q. It is the  
12 Commissioner starting and he says:

13 "THE COMMISSIONER: But it is your -"  
14 and then we get to the top of page 8276:

15 "...recollection that it was at the  
16 October 23rd meeting that there was  
17 this discussion that took place and  
18 that the team didn't want to be  
19 split. Have I got that right?

20 THE WITNESS: I may not be correct  
21 in my placing it on October 23rd,  
22 it was in the fall but I think it came  
23 out of that meeting.

24 THE COMMISSIONER: And you say the  
25 team said they did not want to be  
split, is that it?

THE WITNESS: Yes.





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"THE COMMISSIONER: I don't want you to concern yourself about this but do you remember who said that, you see teams don't speak normally unless they are cheerleaders, they don't speak with one voice. You don't remember which one?

THE WITNESS: No."

What I got from that, No. 1, quite obviously whoever it was and I think you also said a lot later you didn't know where this came from, but whoever it was somebody had brought up that a solution here to this jinxed feeling was that maybe the team should be split up?

A. That is correct.

Q. Can we say that that suggestion definitely came at least from beyond the team itself, be it from cardiologists, or be it from other nurses or other teams, somebody brought up the issue of splitting up the team?

A. I am not sure that it came from outside the team themselves. If it did I believe that it came from nursing administration not from outside of that.

Q. That is what I meant, nursing







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administration itself would seem to me the logical place that it might have come from. You say you are not sure that it didn't come from outside the team. Would that not be inconsistent with your evidence here, as the feeling it was coming from the team was that they didn't want to be split up, that is what your evidence seems to say?

A. The team didn't want to be split up?

Q. Yes.

A. That was true.

Q. So it would hardly be likely that the team itself brought up the idea at one and the same time that we should be split up but we don't want to be split up?

A. Well at that meeting we discussed the stresses in general and tried to do some problem solving around, all right, how do we solve the problems so that people are not feeling stressed. It is very logical to me that out of that discussion would come the suggestion that, all right, the teams could be re-organized and then indeed there would not be one team that would feel jinxed, if you will.

Q. All right. My only question





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then is that logically that came from beyond the  
members of the team bearing in mind what you told  
us here yesterday, somebody from beyond the team  
suggested maybe the solution was to split them up.

A. I don't know if it came  
beyond the team, if it came in the context of that  
meeting then it would have been the team along with  
other nursing staff.

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Q. It might have been made in  
their presence?

A. Yes.

Q. But I am saying that the  
idea of a split in the team came from beyond members  
of the team itself?

A. I cannot say necessarily.

Q. Well, I do not want to be  
nitpicking here. How could it be any way else, given  
the evidence that I have just read to you when you  
said the team did not want to be split up?

A. Well, given the situation  
that you are feeling stressed, what are the solutions  
in handling that stress, one of those being to  
request a psychiatrist to be involved, what else  
could you do, I could see nurses problem solving that  
themselves, that we could, and say as a team perhaps  
it would be better if we did not work together.

Q. So you are saying they might  
have brought it up as sort of a proposed solution  
and later in the meeting perhaps expressed their  
desire, though, whatever, about it being a solution,  
that is not a solution we really are too favourable  
towards?

A. That is right.





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Q. All right. In any event, you are clear that they did not want to be split up. Did it ever strike you as unusual or odd here that the very team that is complaining about all this stress, the team that thinks perhaps they are jinxed at one and the same time are resisting what to me is the most obvious and logical solution, as Mr. Labow said, the movement of one person to another team, in exchange for another person?

A. That did not seem unusual to me. I think to propose that the team be changed is to say yes, we are jinxed, there is something wrong with us. It is to say we cannot work together and we are not doing a good job. That was not how they felt.







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A. No.

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Q. I think it was in the memo?

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THE COMMISSIONER: I thought it was  
in either a memo or ---

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MR. SHANAHAN: Q. Mary Costello's  
notes?

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A. Was it in the notes from this  
morning?

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Q. Yes, those contraversial  
notes from this morning. There is mention here of ---

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THE COMMISSIONER: On page 2.

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MR. SHANAHAN: Have you found it  
there, Mr. Commissioner?

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THE COMMISSIONER: Well, I think I  
have.

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MS. FORSTER: Mr. Commissioner,  
page 2 does not indicate anything about Miss  
Trayner's strange behaviour. There is a reference  
to Miss Trayner's behaviour and I think, sir, that  
you indicated this morning since this part of the  
note had nothing to do with the meeting at which  
this witness was present it was appropriate to ask  
somebody about ---

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THE COMMISSIONER: Well, she  
certainly was not present at the part with Miss Nelles,

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but I am not too sure, did you also say you were  
not there when there was some discussion about Miss  
Trayner's behaviour?

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THE WITNESS: I do not believe  
Miss Trayner's behaviour was discussed at that  
meeting.

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THE COMMISSIONER: I see. Yes, that  
is quite possible, I am sorry, yes, that is right.  
That might not have been discussed at the meeting  
at all. Do you remember anyone discussing anything  
at any meeting about Miss Trayner's behaviour?

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THE WITNESS: No.

THE COMMISSIONER: Did you yourself  
make any observations about Mrs. Trayner's behaviour?

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THE WITNESS: No, not that it was  
unusual behaviour in any way.

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THE COMMISSIONER: I am sorry?

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THE WITNESS: Not that it was unusual  
behaviour.

MS. CRONK: You will recall, sir,  
it arose in a different context this morning, as  
well, during the cross-examination by Mr. Young when  
he put to the witness the suggestion that two other  
nurses had complained to Ms. Browne about the  
behaviour or activity of Ms. Trayner and she





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indicated that she had no recollection of such an  
event and he did not pursue the matter further.

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MR. SHANAHAN: Q. So your evidence  
then is you do not know of anything directly and  
you never heard of anything about any behaviour of  
Ms. Trayner that was ontoward or out of sorts?

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A. No.

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Q. Or anybody having difficulty  
working with her because of strange reactions from  
her?

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A. No, I was aware of the conflicts  
that have been talked about earlier, but apart from  
that, no.

Q. About the preparation of  
formulas here, if a nurse was in 418, both of my  
clients' children died in 418, if a nurse was in there  
with constant care, looking after those children,  
in your experience could another nurse, is it some-  
thing that occurs that another nurse might go out  
and prepare the formula and the feed for the nurse  
that is doing the constant care?

A. Primarily the feeds were  
already prepared, another nurse might go and get  
the feed for her, yes.

Q. Already prepared outside of the





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Hospital? I am missing something here.

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A. Some are prepared outside of

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the Hospital.

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Q. And some prepared in the

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Hospital?

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A. And some are prepared within

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the Hospital.

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Q. By staff other than nurses?

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A. Yes.

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Q. All right, but another nurse

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may go and get, we will say, the Lombardo baby's  
formula?

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A. Yes.

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Q. And bring it to the nurse that

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would then feed the baby?

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A. Yes.

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MR. SHANAHAN: All right, thank

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you.

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THE COMMISSIONER: Yes, all right,

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thank you, Mr. Shanahan. I guess we will reserve  
the pleasure until tomorrow morning, Mr. Tobias.

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MR. TOBIAS: Yes, Mr. Commissioner,

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I would prefer that.

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THE COMMISSIONER: Yes. How long

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will you be?

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MR. TOBIAS: I would think about  
15 minutes, Mr. Commissioner.

THE COMMISSIONER: Yes, all right.  
Thank you. Then we will rise until 10 o'clock  
tomorrow morning.

---Whereupon the hearing adjourned at 4:30 p.m.  
until 10:00 a.m. Thursday, December 22nd, 1983.





